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ABSTRACT

These 12 monthly issues, one special report, amd index from 1997 explore problems encountered by children and adolescents. Regular features include "Keep Your Eye On...," brief accounts of research into childhood and adolescent problems; "What's New in Research," summarizing research from recent publications and professional conferences; "Commentary," editorials from professionals working with children and adolescents; "Announcements," events and conferences of interest; book reviews; and client handouts for use by practitioners. Major topics include: (1) studies of massage therapy for childhood conditions, teen dieting and drinking, asthma in black children (January); (2) linking early childhood behavior patterns to adult psychiatric disorders and teen suicide risk (February); (3) studies of chidhood antidepressant use, toilet training, obsessive-compulsive disorders, abused children and post-traumatic stress disorder (March); (4) studying music to enhance math and science skills, antipsychotics, and artificially conceived twins (April); (5) chronic tics, and prenatal cocaine exposure (May); (6) teen suicide, and perception of asthma symptoms (June); (7) poor children's social competence, depressed mothers and touch interventions, and parents' use of time (July); (8) infant/toddler case and education, treatment for depressed adolescents, drug/alcohol/cigarette availability for rural/urban teens (August); (9) interracial children (Special Report); (10) infant development, spanking and hitting are perilous, prenatal exposure to maternal infections and cerebral palsy risk (September); (11) identity development and racial grouping, depersonalization disorder, and security objects (October); (12) precocious reading, emotionality and social competence, eating disorders in men, and child neglect and borderline personality disorder (November); and (13) maternal negative nonverbal behavior with toddlers, and metabolic abnormalities in murderers' brains

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

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Treatment

Massage therapy is effective for many childhood conditions

By Tiffany M. Field, PhD

Massage therapy is proving to be an effective therapy for children and adolescents with medical and psychological problems. In our studies with children, we use parents as the massage therapists; the children can be massaged daily at no cost; and the parents can feel less helpless and more involved in the child's treatment. Parents' involvement in their children's treatment is often negative because they must give shots or monitor dietary compliance, as with diabetic children. Being involved in a more positive treatment such as massage therapy can be very helpful to these parents.

> ***Massage therapy has generally resulted in lower anxiety levels, lower stress hormones, better mood and improved clinical course.***

Asthmatic children

Asthmatic children were given daily 20-minute massages at bedtime by their parents for a one-month period. At the end of the study the parents' anxiety decreased, and the children's anxiety and stress hormone levels decreased. Most importantly, over the one-month period, the children had fewer asthma attacks and were able to breathe better based on daily peak air-flow readings.

Autistic children

In this study, we wanted to determine whether massage therapy improved the classroom behavior of preschool autistic children. Data analyses revealed that after one month of massage

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Inside This Issue

Dieting in the sixth grade predicts drinking in the ninth grade, new research suggests.
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Asthma is overdiagnosed in black children. Researchers offer an explanation.
See page 4

Some thoughts about our perennial wish to be better than we are.
See page 8

This month's client handout
Helping the pregnant teen sort through the options

Adolescents

For some teens, abortion as a means of coping can become a stressor

By Anne Speckhard, PhD

Each year, almost 1 million teenagers in the United States, 8 percent of 14-year-olds and 11 percent of all girls ages 15 to 19, become pregnant. Of these, nearly 40 percent abort their pregnancies.

Abortion in these situations is typically resorted to as a coping mechanism; most adolescents are not well-prepared for parenthood, and adoption is not an easy alternative. However, for some teens abortion itself can be a traumatic stressor.

While there are currently no national data sets on post-abortion stress reactions, a pilot study following up abortion clinic attendees found approximately a 20 percent posttraumatic response to abortion. Likewise, indications of depression following abortion also appear to fall in the 20 percent range. Researchers on the issue agree that later-term abortions, coercion, lack of emotional development and other risk factors can combine to make the abortion experience more stressful.

Why some teens do not do well with abortion, while others do, is a function of how the teenager perceives the experience. Developmen-

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Massage therapy

from page 1

therapy, the autistic children a) were less touch-aversive; b) were less distracted by sounds; c) were more attentive in class; d) showed better relationships with their teachers; e) received better scores on the Autism Behavior Checklist (sensory, relating and total scale scores); and f) scored better on the Early Social Communications Scales (joint attention, behavior regulation, social and initiating behaviors). These were very surprising findings because we expected, based on anecdotal reports, that autistic children would find massage — as with other forms of touch — aversive. Instead, they enjoyed massage. Massage may be less aversive than other kinds of touch because it is predictable. Autistic children may find unpredictable stimulation too arousing.

Children with severe burns

This study was designed to reduce anxiety levels prior to the very painful skin-brushing procedure that burn patients experience, and thereby reduce pain during this procedure. Since massage therapy is noted to decrease levels of anxiety and stress hormones in children, we used this therapy prior to the anxiety-provoking, painful skin brushings. After one week, the children had lower anxiety levels and lower levels of stress hormones.

Cancer

In this study, the children were massaged prior to chemotherapy sessions to reduce anticipation anxiety/nausea (short-term effects). The parents also massaged their children prior to bedtime to help them sleep and to give parents an active positive role in their children's treatment. Other benefits included decreased touch aversion (sometimes noted in children with cancer) and improved immune function. In turn, massage could reduce opportunistic infections such as pneumonia in children with cancer.

Dermatitis in children

In this study, stress levels were reduced (stress levels are known to contribute to skin allergic conditions), and having the parents give the massage helped the parents' treatment compliance and reduced their aversive reaction to touching the dermatitis area (and the child's sense that others have an aversive reaction). Finally, measures of the children's skin condition suggested clinical improvement.

Diabetes

Parents' typical involvement in treatment of this condition, as with monitoring dietary compliance and taking blood samples and giving insulin shots, is negative. We gave parents a more positive role in their children's treatment by having them massage their child daily before bedtime. Immediately after the massage sessions, the parents' and children's anxiety and depressed mood levels decreased. At the end of one month, blood glucose levels had decreased to a low value within the normal range.

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Eating disorders (bulimia)

Adolescents with eating disorders such as bulimia or anorexia are typically depressed. In this study, we hoped to decrease depression and anxiety and to improve the body images of adolescents who were hospitalized for bulimia. The adolescent girls were massaged twice weekly for a five-week period. Data analyses revealed the following significant effects: the massaged adolescents had a) fewer depressive symptoms; b) lower anxiety levels; c) a less distorted body image; and d) lower urinary cortisol levels.

Juvenile rheumatoid arthritis

Children with this disease experience chronic pain because anti-inflammatory agents have ceiling effects and narcotic drugs cannot be used due to the addiction risk. Thus, other pain-relieving therapies are being explored. In a massage therapy study in which parents gave daily massages to their children, preliminary data analyses comparing massage and progressive muscle relaxation revealed that the massage therapy group showed several advantages: a) a greater decrease in anxiety and stress hormone levels (cortisol) after the first and last sessions; and b) a greater reduction in pain over the one-month period.

The growing role of managed care in child-welfare services and a move toward more innovative approaches to behavioral health research are just two of the trends explored in the Special 1997 Preview Issue of *Mental Health Weekly*, Manisses Communications Group's policy newsletter for mental health professionals. Also included in the issue is a column of 1997 predictions by Charles G. Ray and Lee Ann Slayton of the National Community Mental Healthcare Council. To receive a *free* copy of the special issue, call Manisses' customer service department at (800) 333-7771.

Posttraumatic stress disorder (PTSD)

This study was conducted with children who were traumatized by Hurricane Andrew and displayed behavior problems in the classroom. The children were massaged at their school two times weekly for one month. A control group watched relaxing videotapes during their sessions. The results showed that the massaged children had less depression, lower anxiety levels and lower levels of stress hormones, and their drawings had fewer depressive and disorganized features.

Psychiatric problems

In this study, we gave a 30-minute back massage to 52 hospitalized depressed and conduct-disordered adolescents every day for a five-day period. The following significant differences were found between the control group, who watched relaxing videotapes, and the massage therapy group: Massaged children a) were less depressed; b) were less anxious; and c) had lower saliva cortisol levels after the massage therapy sessions. After five days, nurses rated the adolescents as being less anxious and more cooperative; nighttime (time-lapse videotaped) quiet sleep increased; and urinary cortisol and norepinephrine levels decreased.

Summary

Massage therapy has generally resulted in lower anxiety levels (both self-reported and observed), lower levels of stress hormones (cortisol and norepinephrine), better mood (less depression) and improved clinical course. Other findings were unique to specific conditions.

Massage therapy may work by increasing vagal activity, slowing down the nervous system to a more alert, relaxed state in which people characteristically feel better, perform better, are able to sleep and are less likely to get sick. Enhanced attentiveness or decreased off-task behavior in our studies on autistic and attention-deficit disorder children may relate to increased vagal activity. Lower heart rate and greater heart rate variability generally accompany attentiveness. Increased quiet sleep, which we have noted in our studies on child and adolescent psychiatric patients and infants of depressed mothers, may derive from increases in vagal tone and parasympathetic dominance. Enhanced quiet sleep might also relate to the reduction in anxiety and depression levels noted across most of our studies.

The reduction in pain noted during our studies on children with burns and juvenile rheumatoid arthritis could relate to the "gate theory" of pain. The theory posits that, because touch or tactile nerve fibers are longer than pain fibers and because they are more myelinated, their transit time to the central nervous system is shorter and they "close the gate" to the slower moving pain signals. A similar phenomenon has been noted by Elliott Blass and his colleagues at Cornell University, who report both an opiate-mediated, pain-alleviating mechanism (for example, using sucrose to reduce pain in preemies as they receive heelsticks) and a non-opiate-mediated, pain-alleviating mechanism that needs to be further explored as a potential explanation for pain reduction following non-nutritive sucking (intraoral stimulation) in preemies. An increase in serotonin also may contribute to these effects (serotonin being the base of many pain medications and antidepressants).

Continuing multimethod/multivariable research is needed on the effects of massage therapy with infants and children. ■

Tiffany M. Field is director of the Touch Research Institute at the University of Miami School of Medicine's department of pediatrics. For more information, contact her at PO Box 016820 (D-820), 1601 N.W. 12th Ave., Miami, FL 33101.

What's New in Research

Poverty has strongest effect on children's health

After studying the effects of family structure, poverty and race on children's health, researchers have found that poverty has the strongest effect. In an analysis of National Health Interview Survey data collected from 1978-1980, and from 1989-1991 (with each year's survey comprising more than 40,000 households), researchers found that poor black children and poor white children were more than twice as likely to be in fair or poor health than were more affluent children. Within each socioeconomic category, black children had higher rates of fair/poor health than did whites. Data gathered in the 1989-1991 survey found that children in single-mother families were 2.6 times as likely to have fair/poor health as were children in two-parent families. The association between children's health and low family income was not explained by race or family structure.

"The effects of poverty, race, and family structure on U.S. children's health: data from the NHIS, 1978 through 1980 and 1989 through 1991." L.E. Montgomery, MA, et al., *American Journal of Public Health*, 86(10):1401-1405, 1996. For reprints, call Laura Montgomery at the National Center for Health Statistics, (301) 436-3650, ext. 177.

Early dieting predicts drinking

Recent research found that frequency of dieting in sixth grade was a more powerful predictor of future drinking than such parameters as others' approval of alcohol use, perceptions of peer use of alcohol, and personal feelings of shyness and self-satisfaction. Data from 1,905 participants in a middle school health promotion project were analyzed. The researchers found a positive, graded relationship between the frequency of dieting in the sixth grade and the frequency of alcohol intake in the ninth grade. The authors suggest that because dieting is a marker for both girls and boys who are at greater risk of beginning to drink in the middle school years, those students who begin dieting early might reasonably be targeted for future drinking prevention interventions. Furthermore, they say that drinking prevention programs probably should include specific content addressing dieting behavior.

"Dieting in sixth grade predicts alcohol use in ninth grade," Dean Krahn et al., *Journal of Substance Abuse*, 8(3):293-301, 1996. For reprints, write to Dean Krahn, William S. Middleton Memorial Veterans Hospital, 2500 Overlook Terrace, Madison, WI 53705.

Children of drug abusers lack social, cognitive skills

The effects of parents' illicit drug abuse on latency-age children include symptoms of anxiety, depression, low self-esteem, difficulty in self-regulation of behavior and inability to focus and sustain assigned tasks. Latency-age children from drug-involved homes often lack the social and cognitive skills necessary to meet the demands of the educational process. In addition, their ability to acquire these skills in school may be significantly compromised by the psychic energy required to manage feelings about what is occurring at home, the authors say. Unlike the common situation in alcoholic families, in which one parent abuses alcohol and the other does not, in drug-abusing families a sober parent is seldom available to seek out and manage a course of treatment for the child. Thus, schools located in communities with high rates of drug use are logical sites for the kind of group-based preventive intervention that would address such protective factors as promoting social competence and strengthening interpersonal skills. Offering these children a time-limited, structured group experience that addresses concerns about parental substance use and teaches them alternative coping strategies can help reduce anxiety and heighten self-management skills that, in turn, will reduce social isolation, enhance self-esteem, reduce problematic behavior and heighten learning in the classroom, the authors say.

"Psychosocial functioning and treatment needs of latency-age children from drug-involved families," Martha Morrison Dore et al., *Families in Society: The Journal of Contemporary Human Services*, December 1996. For reprints, write to Family Service America, Inc., 11700 W. Lake Park Drive, Milwaukee, WI 53224.

Asthma is overdiagnosed in black children

In a closer look at the widespread finding that asthma is more prevalent among black children than among white children, researchers found that black race may be more important to a child's acquisition of a diagnosis of asthma than the presence of symptoms, such as a persistent wheeze. The researchers assessed the predictors of diagnosed asthma and of persistent wheeze in 1,416 children of both races in Philadelphia. Almost twice as many black as white children were reported by their parents as having been diagnosed with asthma, yet black children were not significantly more likely than white children to have a persistent wheeze. One factor in the overdiagnosis of asthma may be urban poor children's inadequate, episodic care: They may see doctors with whom they have little history and who may be quick to mislabel a wheezing episode as asthma.

"Race, asthma, and persistent wheeze in Philadelphia schoolchildren," J. Cunningham et al., *American Journal of Public Health*, 86(10):1406-1409, 1996. For reprints, call D.W. Dockery, ScD, Harvard School of Public Health, (617) 432-1244. Also, from "Editorial: social class and asthma — distinguishing between the disease and the diagnosis," P. Gergen, *American Journal of Public Health*, 86(10):1361, 1996. For reprints, call Peter Gergen, MD, Agency for Health Care Policy and Research, (301) 594-1357, ext. 1310.

Keep Your Eye On

... birth rates.

Preliminary data from the Centers for Disease Control and Prevention (CDC) show a slight drop in the number of births to teenagers and to unmarried women.

In 1995, the preliminary birth rate for teenagers (56.9 births per 1,000 girls ages 15 to 19 years) declined 3 percent from 1994 — continuing a trend that started in 1991. Rates declined up to 3 percent for white, American Indian/Alaska Native, Asian/Pacific Islander and Hispanic teenagers, and 9 percent for black teenagers.

The number of births to unmarried mothers also declined 3 percent to an estimated 1,248,028, and the proportion from 32.6 percent to 32 percent, from 1994 to 1995. For the first time since 1976, the birth rate for unmarried women ages 15 to 44 years declined — from 46.9 per 1,000 in 1994 to 44.9 in 1995, a 4 percent decline.

That makes 1995 the first year since 1940 (when national statistics first became available) during which concurrent declines occurred in the number, rate and proportion of births to unmarried women. Compared with 1994, the 1995 proportions of births to unmarried women for whites and blacks declined by approximately 1 percent, and for Hispanics by 5 percent.

Other data of note: In 1995, the incidence of low birth weight (less than 2,500 grams) was unchanged from 1994 (7.3 percent); the proportion of births by cesarean delivery (20.8 percent) declined for the sixth consecutive year; and the proportion of mothers beginning prenatal care during the first trimester (81.2 percent) increased for the sixth consecutive year.

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... environmental toxins.

A report released by the Environmental Protection Agency (EPA) that details health threats children face from toxins in the environment sets forth a new national agenda to protect children from those risks more comprehensively.

"We've learned that children face significant, long-term and unique threats from environmental toxins," says EPA administrator Carol M. Browner. "For the first time, this report looks comprehensively at the impact of environmental pollution on children, and we believe that we must take a comprehensive approach to providing children with stronger health protection."

Among the report's findings:

- Asthma deaths among children and young people increased by 118 percent between 1980 and 1993, and asthma is now the leading cause of hospital admissions for children.
- Children exposed to tobacco smoke at home have 16 million more days of restricted activity and 10 million more days of bed confinement, and miss 7 million more school days each year than other children.
- Lead poisoning affects as many as 1.7 million children ages 5 and younger.
- Ten million children under the age of 12 live within four miles of a toxic waste dump.

The agenda described in the report includes several specific actions to provide better protection of children's environmental health by setting protective public health standards, expanding scientific research and providing families with expanded right-to-know information.

... preteens and vaccines.

Eleven- and 12-year-old children should see a doctor to get vaccines they skipped and new ones that have become available since they were babies, the government recently recommended.

The Centers for Disease Control and Prevention (CDC) is establishing this policy of routine visits to make sure adolescents are up to date on their shots and are able to see what other immunizations they might need," says John Livengood of the CDC's epidemiology and surveillance division.

Most infants get a series of baby shots to ward off most childhood diseases and hepatitis B. But the hepatitis vaccine was not recommended as a routine shot until 1991, and a vaccine against chicken pox has been available only since May 1995, so preteens would not have had the shots as babies. The CDC says:

- One in five children ages 11 and 12 are at risk for chicken pox because they haven't had the disease or the vaccination.
- There are 200,000 new hepatitis B infections each year, 70 percent of them among people ages 15 to 39.
- While measles is declining overall, 17 outbreaks in the United States this year occurred mostly among children ages 10 and older.

"The great value of this visit is to not only generally check that all immunizations are up to date but to catch up with adolescents before they become sexually active," says Dr. Gregory A. Poland, chief of vaccine research at the Mayo Clinic in Rochester, MN. "It's also a perfect time to talk to them about seat belts, drug use, suicide," he says. "The whole idea is to reach these budding adults before they get sick." (Associated Press)

... adolescent assault victims.

According to a task force report from the American Academy of Pediatrics (AAP), hospital emergency departments do not have care guidelines that address the psychosocial needs of adolescent victims of assault. The AAP's Task Force on Adolescent Assault Victim Needs has developed protocols specific to each hospital professional treating victims of violence. According to the academy, adolescent victims of violence often are treated in the same way as young victims of accidents are. The task force advises professionals to address victims' psychosocial needs as well as their physical treatment, because psychological damage that remains unresolved can contribute to reinjury or reactive violence. The task force concludes that treatment for adolescent assault victims should be multidisciplinary, with involvement from a variety of health care professionals. (*Pediatrics*, October 1996)

... children who cannot feel pain.

A small group of nine Italian children who can't feel pain or cry has attracted the attention of New York-based experts who hope to better understand the rare genetic disorder, known as hereditary sensory and autonomic neuropathies (HSAN).

Because the young victims also battle problems that are part of much more common diseases, such as diabetes, the doctors say knowledge gained from this small group of patients could benefit millions.

The study was inspired when the parents of a 9-year-old girl, frustrated by the lack of a definitive diagnosis, put out a plea for help on the Internet. A man in Wisconsin directed the family to Dr. Felicia Axelrod, an expert in HSAN at New York University Medical Center. Axelrod diagnosed the girl as suffering from type four of HSAN, one of the rarest forms. Because the child cannot sweat, even a small fever can be fatal. And because she feels no pain, she once ran around on a broken leg for months, deforming the bone and necessitating a long spell in a waist-high cast. The family knew of some eight other children with symptoms like their daughter's, and so, Axelrod brought a team of experts to Italy to study the group. (Associated Press World News)

Abortion

from page 1

tally, teenagers are moving away from their families and forming new attachments. They are trying on new roles and responsibilities. One of these new roles is seeing oneself as a potential parent. A teen who becomes pregnant will often form a strong attachment to the fetus even if she knows she cannot carry the pregnancy to term. This is problematic in that the disrupted attachment that occurs with abortion can create a grief reaction that is difficult to overcome.

For many teens the world is still seen in terms of black and white, with little gray in between. Abortion is, for some adolescents, viewed as a death event with the person responsible for the abortion as guilty of taking a life. For a teen who has these views of abortion, ambivalence and guilt over abortion often appear.

Teens are often late to discover their pregnancies and frequently hide or go into denial over pregnancy. As a result, their pregnancies are often far advanced at the time of the abortion and the degree of attachment that has occurred and the moral concerns over the abortion issue are further complicated by the advanced fetal development.

For anyone, teen or older, who experiences abortion as involving a death event, the experience conforms closely to the criteria defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) for a traumatic event capable of causing posttraumatic stress disorder (PTSD).

The DSM-IV defines a traumatic event as one in which both of the following were present:

(1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness or horror.

Adolescents who are traumatized by their abortion experience often say they felt forced to have an abortion and that the experience was one of overwhelming emotions from which there was no escape. Well-meaning parents and abortion providers sometimes use rather strong persuasion to prevent a teenager from "ruining her life" by going through with an ill-timed pregnancy.

The posttraumatic stress that sometimes follows an abortion experience is similar to that following other traumas. There is usually a dissociative defense erected during the trauma, which may be experienced as emotional numbing. One teen related that she lay on her bed prior to the abortion procedure, stroking her belly and talking to her fetus about not wanting to have an abortion, but when she got up to go to the clinic she put her feelings of attachment and loss away "in order to go through with it." Flashbacks of feelings of attachment to the imagined child often return after the abortion, which may fuel a desire to deny that the abortion even took place. For some adolescents, the "deceased child" lives on in fantasy as a means of avoiding grief.

Flashbacks and nightmares often contain gruesome imaginings of the dismembered fetus, feelings and sights encountered during the abortion and fears of punishment and grief over the loss of the fetus. To deal with these intrusive thoughts and feelings, some adolescents follow the same coping efforts that PTSD veterans use. They resort to drugs and alcohol to control the flashbacks, to sleep and to help them feel normal. Others develop a sense of self-hatred and throw themselves into self-destructive actions, including promiscuous sexual behavior.

The posttraumatic stress for teenagers often includes re-enactment and acting out of unresolved emotions. One young woman who could not deal with her posttraumatic flashbacks returned to the clinic in the middle of the night, pounding on the doors saying, "Give me back my baby; I want my baby back." Another resorted to clinic violence, attempting to burn a clinic that was scheduled to open on the anniversary date of her abortion experience. Lorena Bobbitt's famous crime in which she mutilated her husband's genitalia occurred within days of her allegedly coerced abortion, and Bobbitt was on record as having gone to her gynecologist complaining of overwhelming emotions arising around that time period.

One public school's nurse commented that although she feels abortion is a good choice for ill-timed pregnancy, the results are not invariably good. She remarked that the teen patients that she had recommended for abortion always came back pregnant again, refusing in their subsequent pregnancy to even consider adoption as an alternative, as they were now so guilty over having had an abortion.

Treatment of post-abortion syndrome (PTSD following an abortion) involves addressing three aspects of the experience: (1) feelings of horror, fear and helplessness; (2) feelings of guilt; and (3) feelings of unresolved grief. Most post-abortive women feel that they are abnormal if they have a negative reaction to abortion. Indeed, many find that their emotional reactions are invalidated by those around them. Given the developmentally judgmental peer group adolescents often return to, a negative reaction to abortion may not be met with much comfort. Adolescent trauma victims, like their adult counterparts, need to be reassured that they have not encountered the politically incorrect trauma. Their feelings of horror need to be accepted and worked through as their own individualistic response to abortion, no matter how well the abortion decision may have served them and despite others' views on the subject.

The posttraumatic decline for teenagers often includes a high degree of re-enactment and "acting out" of unresolved emotions.

Likewise, feelings of grief and guilt often need to be explored within the teen's cultural background and own developing belief system concerning forgiveness, death and the hereafter. Many post-abortive girls find it difficult to forgive themselves and fear punishment from God. Each needs to be directed to explore within her belief system to find the means of forgiveness and reconciliation that can restore her sense of esteem and belonging to her community. Likewise, grief needs to be handled within the teen's view of the afterlife and within her expectations concerning death.

It is not unusual for a mother to wish to rejoin her child in death. Expressions of suicidal wishes after an abortion should naturally be taken seriously; however, they can also be an expression of deep emotional pain, survivor guilt and the wish of the adolescent to undo the death and to rejoin her fetal child. While a wish to stay connected with the deceased child is normal, a preoccupation with the aborted fetus is not. Severing of morbid attachment must occur for the mourning process to be completed. When unresolved grief persists, emotional energy that should be available to invest in new relationships remains locked up in prior traumatization.

Teens who have a difficult time with abortion may find some of their emotional responses to it resurfacing with future fertility events. Anniversary reactions and fears for future pregnancies should be anticipated in the therapy relationship. Many of these concerns can be worked out ahead of time so that they are less unbalancing when they occur. A teen who has made an abortion decision that she experiences traumatically and later regrets can, with help, consolidate a positive sense of self to carry forward into her future life and childbearing. ■

Anne Speckhard is a psychotherapist in private practice in the Washington, DC metro area. Her doctoral dissertation, at the University of Minnesota, was on psychosocial aspects of stress following abortion. You can write to Dr. Speckhard at Advances in Health, 4009 David Lane, Alexandria, CA 22311, or send her e-mail at speckhard1@aol.com.

Commentary

I hereby resolve that ...

There is something about "the New Year" that excites diverse and interesting emotions and expectations in most of us. The New Year comes right after the season of holidays of mostly religious origin, prompting concern with and discussion about what we have, what we have lost and what we wish might be different.

Children pick up on the solemn attitudes as well as the joys associated with anticipation of "better times ahead" that are expressed especially strongly at the end of the calendar year. The flavor of the celebration is emphasized with special presentations by the media at this time of year, especially about good deeds, good people, charitable causes and heroism. Wishful thinking is vividly caught in children's remarks, such as "If I am better next year, maybe I'll get more gifts than I did this year." Adult equivalents go something like this: "If I put in a bit more effort, maybe I can get that promotion." This kind of wishful thinking is probably what led to the custom of New Year's resolutions. There is a sublime awareness in it all that our own behavior makes a difference, one of the first lessons that children learn about the real world.

> *There is a sublime awareness that our own behavior makes a difference, one of the first lessons that children learn about the real world.*

At the root of it all, too, is our sensitivity, acquired early in life, to the devastating condition of loss that all children have experienced in one or more ways, and the fantasy that the loss did not really occur or that the loss is reversible.

Quite possibly the most important aspect of the human condition is that we become attached — to people and things. The natural result of the disappearance or loss of these things and people is grief, regret or sadness, and the wish that somehow our lot had been different. The British essayist William Hazlitt said that humans are the only creatures that laugh and cry, because we are the only ones that can understand the difference between the way things are and the way they might be. At the time of the year when we celebrate both the solemnity of life and the prospect of renewal, Hazlitt's wise observation becomes ever more poignant.

In all seriousness, there is also a comedic aspect often accompanying the wish that things might be different. New Year's Eve resolutions are perhaps as often honored in their breach as in promise and commitment. W.C. Fields was asked at a holiday party to say a few words. He raised his glass and accommodated with: "At this time of year it is well to think about our friends, and to thank them for their loyalty. It is also a time of year when we should be concerned with forgiveness. In the spirit of the season, I should like, therefore, to say that I forgive everyone except two." ■

Lewis P. Lipsitt

Dr. Lipsitt is editor of *The Brown University Child and Adolescent Behavior Letter.*

Recommended Reading

Against My Better Judgment: An Intimate Memoir of an Eminent Gay Psychologist — *Roger Brown, Harrington Park Press, Haworth, 253 pages, $29.95.*

Just off the press, this is an extraordinary account of an aging gay man's life after losing his companion of 40 years. Readers are finding it shockingly frank. Some say he shouldn't have written it. Others say it was fine to write it, but he shouldn't have published it. Both miss the point: Roger Brown is a wonderful writer and one of Harvard's and the nation's finest teachers, as well as a world-renowned psychologist; that is why he should share his story.

Attention Deficit Disorder: Diagnosis and Treatment from Infancy to Early Adulthood — *Patricia O. Quinn, Brunner/Mazel, 240 pages, $23.95*

This book examines the impact of ADD over the lifespan. It discusses causes of ADD, its course with increasing age, use of medication in therapy, non-drug approaches to treatment and legal issues regarding rights of ADD individuals.

For Richer for Poorer: Mothers Confront Divorce — *Demie Kurz, Routledge, 288 pages, $17.95*

The author interviewed women of diverse backgrounds who experienced divorce, to find out what the sources of their concerns were. Some hints: 37 percent of divorced women with children 18 or under live below the poverty level; more than half receive no child support from the father; legal, social and economic conditions in the United States cause resources and living standards of divorced women to go down, regardless of the socioeconomic level of the dissolved partnership.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Assessment

Guide enhances developmental testing for young children

By Emily Fenichel, MSW

A new guide published by Zero to Three: National Center for Infants, Toddlers and Families promotes a comprehensive approach to assessment that builds on strengths and capabilities, not deficits.

Zero to Three (formerly the National Center for Clinical Infant Programs) convened a multidisciplinary parent/professional work group in 1992, with support from the A.L. Mailman Family Foundation. Its work product is the18-chapter volume *New Visions for the Developmental Assessment of Infants and Young Children,* edited by Samuel J. Meisels and Emily Fenichel, which has just been published.

> ***'Assessments shape expectations. That is why they are so powerful.'***
>
> *Susan Rocco,*
> *Special Parent Information Network,*
> *Hawaii*

The guide was developed in order to identify both problems and promising approaches in current assessment paradigms, policies and practices for infants and very young children. *New Visions* includes the perspectives of parents, clinicians and policy-makers from many backgrounds and disciplines who discuss and elaborate the principles of assessment developed by the original work group.

Problems with assessment

Awareness of the importance of a systematic, contextually based approach to the developmental assessment of infants and young children is increasing. However, demands for "immediate expertise" and the pressures associated

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Research links early childhood behavior patterns to psychiatric disorders in adulthood.
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A family history of suicide predicts greater risk for teens.
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Commentary:
Are behavioral problems better treated with pharmacological or psychological interventions?
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Coming next month:
Researchers and clinicians discuss the current controversy over prescribing antidepressants for children.

This month's client handout
Parents are partners in children's learning

Child Psychopharmacology

Some ADHD children on venlafaxine doing well after 42 days

Studies using venlafaxine (Effexor) to treat attention-deficit/hyperactivity disorder (ADHD) in children show that the drug is effective in reducing disruptive symptoms, and it has few side effects, according to James Ferguson, MD, clinical professor of psychiatry at the University of Utah.

The preliminary study also found that children with ADHD showed significant clinical improvement — even those who in addition to ADHD have a more serious problem, conduct disorder, marked by destructive and criminal or near-criminal activity.

"We found that children tend to metabolize venlafaxine more quickly than adolescents and adults," Ferguson says.

A major concern about giving the drug to children has been whether they would be able to tolerate its side effects, but Ferguson and his colleagues say children handle the drug better than adults do.

Ferguson, one of several researchers studying the drug in children with ADHD, said the speed with which the body eliminates the drug could be one reason children seem to exhibit fewer side effects.

Three studies in which the drug

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The Brown University **Child and Adolescent Behavior Letter**

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Keep Your Eye On

... alcohol and children.

Even occasional or moderate drinking may impair a young person's memory systems more than it would an adult's, according to new research.

Scott Swartzwelder, MD, of Duke University's Medical Center, led a team of researchers who found that not only are young rats more sensitive to alcohol-induced learning and memory problems than adult animals, but they also do not get as sleepy from a little alcohol and, thus, they tend to drink more.

"We've shown that the developing brain has exactly the wrong combination of sensitivities to alcohol," says Swartzwelder. "It's capable of staying awake through a prolonged bout of drinking, but at the same time it is sustaining far more damage to memory and learning systems than an adult brain receiving the equivalent amount of alcohol."

Swartzwelder says his studies suggest that as few as two drinks could inhibit learning and memory in a young person, but would have little effect on an adult. (Reuters)

... neurological research.

If there is a window of opportunity for learning language in the earliest years of a child's life, why do more schools wait until high school to teach foreign languages?

There are other examples of how education in the United States is out of sync with the latest research findings in neuroscience, say educators, and they believe it is because neuroscientists rarely talk to educators about what they have learned in their research.

The Education Commission of the States (ECS) attempted to narrow that gap in a workshop held last July that brought together neuroscientists, cognitive psychologists, education researchers and policy-makers to explore recent neurological research findings and their implications for education. Workshop participants recommended that: a major national study be undertaken to develop education policies based on what is known about how children learn; state programs be encouraged to address impediments to brain development, such as prenatal care, maternal nutrition, smoking and drug use; and schools of education be required to expand their teaching of early childhood development.

The workshop proceedings, *Bridging the Gap Between Neuroscience and Education*, are available from ECS by calling (303) 299-3692. *(School Board News,* December 1996*)*

...strep and OCD.

Strep throat might trigger some childhood cases of obsessive-compulsive disorder (OCD), suggesting that penicillin could help, a researcher says. About 1 percent of grade-school children have OCD, according to Susan E. Swedo, MD, acting scientific director of the National Institute of Mental Health.

Nobody knows what percentage of childhood cases may be

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linked to strep throat, says Swedo, but the theory is that the antibodies that are supposed to latch onto strep germs may trigger OCD by mistakenly attacking certain parts of the brain.

One hint of that came from studies of a movement disorder called Sydenham's chorea, or St. Vitus' dance. People with Sydenham's — a complication of strep infections — flail uncontrollably, become clumsy and have speech problems. Scientists found that Sydenham's chorea is caused by strep antibodies mistakenly attacking the same brain areas that are thought to be abnormal in OCD, Swedo says.

In a follow-up study of 21 children with Sydenham's, more than three-quarters had OCD symptoms and about half had enough symptoms to be diagnosed with OCD. In a study of children with OCD, researchers found that a strep throat sometimes seemed to lead to an abrupt worsening of symptoms or an unusually severe first episode of OCD. But, Swedo says, it's too early to recommend giving penicillin to children with OCD to prevent flare-ups of the OCD symptoms, as the approach is still being studied. (Associated Press)

...and hope for a strep vaccine.

Dennis Kasper, MD, of Harvard University has developed a vaccine that one day could protect thousands of babies from the potentially deadly group B streptococcus bacterium, which lurks harmlessly in many women's bodies but can be fatal or brain-damaging if passed to infants in the birth canal.

The National Institutes of Health plans to immunize some pregnant women late next year in studies designed to prove the vaccine is safe enough — and works well enough — to administer to millions of women. The vaccine would prod a mother's immune system to send antibodies across the placenta and provide newborns with strep protection for a few months until the baby's own immune system kicks in.

About 30 percent of American women harbor Group B strep, a cousin of the bug that causes strep throat. Childbirth infects one in 500 of Americans — around 4 million newborns every year. Ten percent die, and up to half suffer long-term damage, ranging from seizures to mental retardation. But, say researchers, it will take several years to finish developing the vaccine — especially since five subtypes of Group B strep exist and Kasper's initial vaccine fights just one. (Associated Press)

...depressed teens' smoking.

Teenagers with depression are 4.6 times more likely to have nicotine dependence than are contented teens, says a new study from the Christchurch School of Medicine in New Zealand.

Edwin Fisher, MD, a professor of psychology and medicine at Washington University in St. Louis and spokesman for the American Lung Association, admits the relationship was found to be that strong. But, he adds, cigarettes can give the illusion of a quick mental fix in times of stress; they energize and elevate mood.

"We need to raise consciousness that adolescence is a time when people go though a lot of self-doubts and periods of feeling blue," Fisher explains. "If you're a parent and your teenager starts to smoke, you ought to be saying, 'Why is my teenager unhappy?' rather than just coming down on them like a ton of bricks." *(Archives of General Psychiatry)*

...hungry children.

Four million children under the age of 12 do not get enough to eat and 20.8 percent of American children under 18 live in poverty, reported a private research group. In a profile of food and nutrition programs in the United States, the Food Research and Action Centre, which works for policy changes to eradicate hunger and malnutrition, based its findings on a survey it conducted in 1995.

The study found that while federal nutrition programs reach a significant number of poor children, last year's changes in the welfare law could undermine this. "Even now, these programs fail to serve all who are eligible; we fear implementation of the new welfare law will undermine the reach of the programs in the year ahead," the Centre said in a statement. Under the new welfare law, the group said, funding for nutrition programs over the next six years is to be cut by $30 billion, including deep cuts in the food stamp program and the elimination of some funding for programs providing breakfasts for schoolchildren. (Reuters)

...bed-sharing.

Sudden infant death syndrome (SIDS) may be prevented if mothers share their beds with their infants, according to research from the University of California at Irvine. Sarah Mosko, MD, associate professor of neurology and the lead researcher, sounded a cautious note about the findings, but she and other SIDS experts say the report marks a critical step in examining ways to prevent the mysterious disease that was blamed for 4,200 deaths in the United States in 1995. Mosko's study shows that bed-sharing, common among Latinos and other ethnic groups, may prevent long episodes of deep sleep.

During this stage, infants, particularly those 11 to 15 weeks old, are most vulnerable to SIDS, which scientists believe occurs when infants inexplicably stop breathing. Normally, when breathing ceases, the oxygen-depleted brain arouses the sleeper and breathing resumes. Although the cause of SIDS is not known, many scientists believe it involves an inability of the brain to arouse the sleeper. The study, published in the journal *Sleep*, does not recommend that parents immediately adopt bed-sharing. For one thing, says Marianne Willinger, a SIDS expert not involved in the research, more study is needed to assess the risk of a parent inadvertently turning over and crushing the infant. Still, Willinger praised the study as a first-of-a-kind look at the phenomenon of bed-sharing that opens a new front in SIDS research. (Times Mirror)

...psychiatric experiments.

State rules regarding psychiatric experiments on children and the mentally ill are unconstitutional, according to a December New York state appeals court ruling. The court found the rules did not adequately protect people who, due to age or illness, cannot give informed consent to take part in experiments.

The lawsuit that led to the decision was filed by patient advocates on behalf of six mental patients who had been committed and treated by court order without their consent. The decision forced the cancellation of at least 10 research projects around the state, including one study that involved spinal taps on suicidal adolescents to monitor the levels of chemicals in their nervous systems.

Jonathan Mareno, an ethicist at the State University of New York's Downstate Medical Center, said the case could set a precedent for other states. John Oldham, MD, director of the New York State Psychiatric Institute, said that if the court's ruling is upheld, many vital experiments simply will not get done. (Associated Press)

...growth hormones.

Short children should be given growth hormones only if they meet specific medical criteria, the American Academy of Pediatrics said in a policy statement aimed at worries about overuse of such drugs.

The group warned its members that the drugs should not be widely used because of the annual cost of up to $50,000, the trauma of three or more shots a week and the physical and psychological risks.

The policy comes amid worries that growth hormones are used simply because a child is short. The National Institutes of Health estimated in 1994 that 20,000 U.S. children have taken the drug, and 8,000 used it solely for cosmetic reasons.

The academy's statement says that clear candidates for growth hormone therapy are children diagnosed with human growth deficiency, which stems from a pituitary gland disorder that can retard growth, and a small number of others, including those with renal difficulties that stunt growth. (Associated Press)

Recommended Reading

THE GROWTH OF THE MIND AND THE ENDANGERED ORIGINS OF INTELLIGENCE — *Stanley I. Greenspan, Addison Wesley Longman, 364 pages, $25*

This interesting work by a noted infant and child psychiatrist proposes that, contrary to the current view of child development experts, intelligence gets its boost more from emotional experience than from cognitive stimulation. His thesis implies that the nature of the relationship between the infant and the caregiver(s) is more important than the specific stimulation afforded. The bottom line: As society becomes more depersonalized, and learning environments more technocratic, the child's relationship with the "teacher" is falling by the wayside. This has serious implications, in Greenspan's view, for society's problems, for example, with violence, ineptitude in situations requiring conflict resolution and, in general, coping with evolutionary and interpersonal risks of all sorts.

CHILD MALTREATMENT AND OPTIMAL CAREGIVING IN SOCIAL CONTEXTS — *Diana Baumrind, Garland Publishing, 175 pages, $40*

This is a scholarly treatment, by one of our best researchers writing on the problems of children growing up, of different family contexts and how they shape the behavior of children. With forewords by Richard Lerner and Paul Mussen, the book details empirical findings relating to various factors influencing the family milieu, such as marital discord, divorce, single-parent status, the role of the difficult child and maternal youth. Child-rearing dimensions relevant to developmental outcome, most particularly those relating to maltreatment, are documented, such as warmth, reciprocity, attachment, coerciveness, confrontation, monitoring, inconsistent discipline and corporal punishment. Baumrind ends with definite recommendations as to how society may yet mend the fabric of child and family policies, which she finds so lacking in good sense.

Parents are partners in children's learning

Parents and teachers may look at young children's learning from different perspectives, but they share a common goal: making sure that children receive the best possible education. Mutual respect and communication between programs and families takes advantage of both perspectives to provide children with the kind of care and education that will help them thrive.

Today's family members and caregivers have many responsibilities and time constraints. It takes extra effort on both sides to build strong partnerships.

Tips for caregivers and teachers:

- **Listen** carefully to parents: They are experts on their own children too. Families can provide important information on a child's behavior outside the program or classroom.
- **Be sensitive** to different cultures and child-rearing beliefs. Never make judgments on parenting styles; always make an effort to respect the family's values and beliefs.
- **Share** pertinent information about the child on a daily basis, especially in programs caring for infants and toddlers. An established system for keeping records and reporting to parents about each child is key to good communication.
- **Welcome** parents into the program or classroom. Ask parents to drop by for lunch or snack, or arrange after-work events like socials or potluck dinners. Working around parents' busy schedules sends a message of being sensitive to families' needs.
- **Communicate** with parents about children's assignments or activities ahead of time. This will allow parents to set time aside for working with their child or coordinate family schedules with school expectations. Parents also appreciate regular, meaningful progress reports early in the year with time and recommendations to help prepare children for the next levels of their education.

Tips for parents:

- **Listen** carefully to what your child's teacher or caregiver has to say. Remember that they spend a significant amount of time with children and share expertise about their development.
- **Don't jump** to conclusions. If you have questions or concerns about your child or the early childhood program, speak directly to your child's teacher, caregiver or program supervisor. Don't panic or merely commiserate with other parents when questions arise.

continued ...

- ☺ **Remember** that many teachers or caregivers have families of their own, and may share similar responsibilities and time constraints. Be as respectful of their time as you wish them to be of yours.

Many early childhood programs today are working hard to become more family-friendly, providing newsletters to parents that focus on staff members and professional development, ensuring one positive phone call per child each semester, or even providing voice mail for parents to leave messages after working hours.

Programs may demonstrate strengths in different ways, but working together with parents remains crucial. When teachers or caregivers make the extra effort to include parents in program activities, and parents take the time to attend and participate, children benefit from the best possible learning experience. ■

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The Brown University Child and Adolescent Behavior Letter

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What's New in Research

Childhood behavior predicts adult problems

For perhaps the first time, adult psychiatric disorders have been linked to behavior patterns that stretch back to childhood, according to a recent study. The longitudinal, epidemiological study of three-year-old children classified the subjects into groups based on examiners' observations. At age 21, they were reassessed using standardized interviews based on DSM-III-R criteria.

The researchers found that children classified as "under-controlled" (impulsive, restless and distractible) were more likely at age 21 to meet diagnostic criteria for antisocial personality disorder and be involved in crime. The "inhibited" three-year-olds were more likely at 21 to meet diagnostic criteria for depression.

Both groups were more likely to attempt suicide, and boys in both groups had problems related to alcohol.

"Behavioral observations at age three years predict adolescent psychiatric disorder: longitudinal evidence from a birth cohort," A. Caspi, PhD et al., *Archives of General Psychiatry*, 53(11):1033-1039, 1996. For reprints, contact Dr. Avashalom Caspi, Dept. of Psychiatry, 1202 W. Johnson St., Univ. of Wisconsin, Madison, WI 53706.

Family history of suicide is risk factor for teens

Teens with a family history of suicide are more likely to attempt taking their own lives than are their peers, a new study has found.

Researchers studied family histories of 58 adolescents between the ages of 13 and 20 and a similar control group. Even after adjusting for depression and personality disorders, relatives of suicide victims still had more suicide attempts or completions than relatives of the control group.

Researchers caution that this is not proof that suicidal behavior is linked to genes. They theorize that exposure to family violence, hostility, separation and loss, low parental involvement or imitation of parental behavior could also explain the tendency. Larger studies are needed to further investigate these findings.

"Suicidal behavior runs in families: a controlled family study of adolescent suicide victims," D.A. Brent, MD, *Archives of General Psychiatry*, 53:1145-1152, 1996. For reprints, contact Dr. D. A. Brent, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, PA 15213.

Resources

Resource catalog available for at-risk youth

The Bureau for At-Risk Youth is offering a 1997 Parenting Edition of their At-Risk Resources catalog. This 32-page catalog describes hundreds of videos, booklets, pamphlets and other materials that focus on improving skills and meeting challenges for better parenting. For more information or to request a free parenting catalog, write to: The Bureau for At-Risk Youth, PO Box 760, Plainview, NY 11803-0760; or call (800) 99-YOUTH.

Child development research fellowship program available

The summer fellowship program for doctoral students at Columbia University's Center for Young Children and Families at Teachers College begins its sixth year.

Putting Children First is a fellowship training program in child and family policy with a developmental perspective, which provides the opportunity to link academic learning across disciplines with interests in social policy.

In cooperation with the Society for Research on Adolescence and the Society for Research in Child Development, *Putting Children First* offers full-time summer placements for eight weeks in a variety of policy settings in New York City government and nonprofit agencies. Fellows also attend weekly seminars at the center, with leading policy scientists and practitioners under the leadership of J. Brooks-Gunn, PhD.

Fellowships begin on June 9 and end on August 1. Fellows receive a $2,800 stipend and a $250 travel grant. Financial assistance is available for university housing. Applicants should send a three-page statement describing their interests in policy and research, a current resumé, two letters of recommendation and a self-addressed stamped postcard. The application deadline is April 18. For more information, contact Dr. Judith Smith, Center for Young Children and Families, Teachers College, Columbia University, Box 39, 525 W. 120th St., New York, NY 10027; (212) 678-3904.

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Assessment accuracy

from page 1

with enormous service challenges present formidable barriers to best practice.

Under pressure to act quickly, professionals may approach assessment in a fragmented manner, rather than performing assessments that reflect full understanding of a young child and his or her relationships within the family, community and culture.

Under pressure to produce quick "scores," professionals may use procedures that were developed for older children. These can often yield misleading information. They are not built on a model of how the infant and young child develop within the family and do not reflect an understanding of the specific types of difficulties and developmental challenges that children and families face in the first three years of life.

There also has been a tendency to assess abilities easiest to measure — those for which there are tests already in existence. Assessments have generally put less emphasis on the aspects of development that are hard to measure and have underemphasized the social and family contexts within which the young child develops.

Most worrisome is the fact that traditional assessment approaches often overlook some of the young child's capacities, particularly those associated with social interactions. This is especially true when an infant or young child has severe relationship and communication difficulties that may interfere with his or her demonstration of seemingly hidden emotional or cognitive strengths.

What makes this one useful?

An assessment will be useful and accurate only if a child can demonstrate his or her optimal abilities. This means allowing parents or other familiar adults to work with the child, using what they already know to discover more about the child's abilities and the challenges he or she is facing. Parents and professionals must observe the range of the child's functioning in different contexts. The goal is not to test or grade a child, but to learn how best to be of help.

An appropriate assessment approach builds on information from family members and adds sources of information, as needed, to help answer questions about the child's development. The sequence includes:

- Establishing an alliance with the parents; listening to their views of the child's strengths and challenges; and discussing the issues to be explored in the assessment.
- Obtaining a developmental history of the child and an initial picture of the family's experience.
- Observing the child in the context of spontaneous, motivated interactions and unstructured play with the parent(s) or other familiar caregivers.
- If appropriate, observing interaction between the child and the clinician.
- Making specific assessments of individual functions in the child, as needed.
- Using a developmental model as a framework for integrating all the data obtained from parents' reports, direct observation and other sources, and conveying and discussing assessment findings in the context of an alliance with the child's primary caregivers, with the potential for starting an intervention process as needed.

Reassessment of a child's developmental status should occur in the context of day-to-day family and/or early intervention activities. Careful observation of the child's behavior in multiple but familiar contexts and on multiple occasions will provide a rich picture of the child's current strengths and chal-

The true purpose of assessment

Developmental assessment is a process designed to deepen parents' and professionals' understanding of a child's competencies and resources, and of the caregiving and learning environments most likely to help a child make fullest use of his or her developmental potential. Assessment should be an ongoing, collaborative process of systematic observation and analysis. It involves formulating questions, gathering information, sharing observations and making interpretations in order to form new questions.

Because the first three years of life constitute a period of such immense change, growth and development, a meaningful assessment of an infant or toddler must:

- ✓ reflect the child's usual functioning;
- ✓ acknowledge the interactivity among areas of development;
- ✓ recognize that both biological and environmental influences operate to support, facilitate or impede the development of infants and young children, and reflect understanding of protective and risk factors in a child's caregiving environment; and
- ✓ take into account how children are affected by the contexts in which they are reared, including both family and community culture.

lenges, as well as the steps to be taken next.

What is *not* useful

Some current practices have no place in an assessment process:

- Young children should never be challenged during assessment by separation from their parents or familiar caregivers.
- Young children should never be assessed by a stranger.
- Assessments that are limited to areas that are easily measurable, such as certain motor or cognitive skills, should not be considered complete.
- Formal tests or tools should not be the cornerstone of the assessment of an infant or young child.

Conclusions

In summary, the developmental assessment of infants and young children should build on current understanding of young children's development. The cornerstone of assessment should be the observation of the child in interaction with trusted caregivers and the appreciation of the child's core functional capacities. Assessment involves multiple sources of information, organized and integrated to obtain a picture of the "whole" child. Incorporating these approaches into assessment should help parents and professionals to deepen their shared understanding of children's competencies and resources, as well as their understanding of the caregiving and learning environments most likely to help children make fullest use of their developmental potential. ■

Emily Fenichel is associate director of Zero to Three: National Center for Infants, Toddlers and Families, a national nonprofit organization dedicated to advancing the healthy development of America's babies and young children. *New Visions for the Developmental Assessment of Infants and Young Children*, from which this article was excerpted, is a 1996 publication of Zero to Three. To order, call 1-800-899-4301, or write to Zero to Three Publications, 734 15th Street, N.W., Suite 1000, Washington, DC 20005.

Venlafaxine

from page 1

was used in children were presented at a meeting of the American Academy of Child and Adolescent Psychiatry.

Ferguson and his colleagues looked at 25 children, including 12 adolescents, between the ages of 6 and 15 to determine toxicity and how the drug is used in the body.

The children were given initial doses of 12.5 mg of venlafaxine a day; after four days, the dose was doubled. Four of the 25 children discontinued the drug before the end of the 42-day study; three others who showed no improvements elected not to continue the drug after the study; five who showed improvement also decided not to stay on the drug at the end of the trial; 13 were continued on venlafaxine.

Another paper presented at the meeting also reported that children were found to handle the drug well and to show improvement in symptoms. "We are encouraged by the work," says Steven Pliszka, MD, associate professor of psychiatry and chief of child psychiatry at the University of Texas Health Science Center at San Antonio.

ADHD and Ritalin

ADHD has been successfully treated with the stimulant drug methyl-phenidate (Ritalin), Pliszka says, but as many as 25 percent of those patients either do not respond to Ritalin or suffer excessive side effects. A second treatment, desipramine, has been curtailed following reports of four sudden deaths of children taking the drug.

Pliszka's study involved 16 children, 14 of whom showed no significant side effects of venlafaxine. More than half the children on the drug showed a significant improvement — a 50 percent decline in symptoms on behavioral tests.

"The data in the studies is sufficient to begin a placebo-controlled, double blind-study of venlafaxine in children with ADD," says Bennett Leventhal, MD, chief of child and adolescent psychiatry at the University of Chicago. "It seems to work biologically and the side effect profile is better than other second-line drugs for ADD."

About 5 percent of children have ADD, Pliszka says; about 2 million children have been diagnosed with ADD; as many as 75 percent of children diagnosed with ADD have received medication for the disorder.

For childhood depression

In a third study, this time using venlafaxine for treatment of depression in children, Miguel Mandoki, chief of the division of child and adolescent psychiatry at the University of Florida, could not find any statistically significant difference between treatment results using placebo or venlafaxine, although both groups of patients showed improvement in their symptoms.

Mandoki says, however, that venlafaxine showed a trend toward significance in treating children who, in addition to depression, also exhibited behavior disorders. ■

Reported by Ed Susman. For more information about these trials in which venlafaxine (Effexor) was administered to children, call: James Ferguson, (801) 261-8930; Steven Pliszka, (210) 567-5400; Miguel Mandoki, (904) 549-3988.

Commentary

Drugs for mind and behavior problems?

It wasn't so long ago that the celebrated psychologist Kenneth Clark, then president of the American Psychological Association (APA), argued forcefully for psychopharmacology researchers and mental health professionals to proceed in all haste to the development and use of drugs to deal with the steadily rising behavior problems of children and adolescents in this country.

This was the same Kenneth Clark, the only black psychologist ever to be president of APA, who provided the convincing testimony to the US Supreme Court that black children, because of segregation, had very low self-esteem and were damaging themselves and others for psychological reasons, i.e., because of bad experiences, and therefore must be allowed to attend integrated public schools.

The court decision was a landmark event leading to legislation that changed the educational system of this country forever, by providing opportunities for advancement of minorities that they had been previously denied.

> *Many individuals whose behavior is troublesome have an investment in presuming that they have a condition beyond their willful control that causes them to behave this way.*

Thus many psychologists were surprised by Clark's emphasis in his APA presidential address on the role of organic or constitutional conditions implicated in misbehavior, and the pharmacological solution he sought for them. This seemed a great departure from his previous emphasis on environmental, experiential causes or psychological problems.

But Professor Clark may have been forecasting a trend, both among many mental health professionals and indeed in our society generally. Today we hear on daily talk shows of individuals who feel they have misbehaved, or have one or another psychological problem, because of some kind of chemical imbalance. They have a "chocolate allergy," they ate too many Twinkies, they are hypersensitive to the air in the building where they work, or they get depressed in badly lighted areas.

Recently, claiming they discovered in adulthood that their mothers drank too much in pregnancy, several adults appeared to say they believed themselves to have "fetal alcohol syndrome." Presidential advisor Dick Morris began his new book *(Behind the Oval Office)* with "explanations" of his high-risk sexual dalliance by saying he was born three months prematurely. Adding that he was "untouched by anyone, even my mother" (clearly an experiential matter), he believes himself to have had a constitutional disorder based on his three-month isolation.

The issue is of immense importance because health maintenance organizations as third-party payers are usually more willing to support short-term or drug therapies for psychological problems; medications often seem to them to offer the promise of shorter (read less costly) therapy. By the same token, many individuals whose behavior is troublesome have an investment in presuming that they have a condition beyond their willful control that causes them to behave this way.

There has been increasing interest in our society in medicalizing human events. The "illness excuse" is now very prevalent in courtroom situations. It is an excuse that has been used extensively by schoolchildren for many years, with parent-teacher support. Almost everyone prefers to ascribe being late for an appointment, speeding, missing a meeting or failing to see a warning sign to a cold, a headache or a sprained ankle.

Why not? Such alibis do succeed in deflecting blame. They are easy to come by, and they are infrequently doubted. They are reinforced from an early age, and children tend to repeat — even throughout their life spans — what has been especially rewarding to them in the past.

Many people, including mental health professionals, have now opted for pharmacological solutions in preference over "talking therapies" for psychological conditions, even those that are quite clearly or largely the result of experience. The nature-nurture conflict, represented even in the wavering personified by Kenneth Clark's advocacies, will be with us until neurobehavioral science succeeds in sorting out the multifaceted causes of psychological problems, and what the best approaches to amelioration are. ■

Lewis P. Lipsitt

Dr. Lipsitt is editor of *The Brown University Child and Adolescent Behavior Letter.*

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special Report: Antidepressants for Children and Adolescents

This month we are sharing with you divergent opinions from members of the New York State Psychological Association, in which there has been a continuing debate about whether antidepressants are appropriate for those 18 years of age and younger. Also, we have asked an officer of "Just Say No" International to provide an update on its progress, even as we await formal empirical evaluations of the efficacy of this and other similar intervention programs – Lewis P. Lipsitt, PhD, Editor.

Science does not support childhood antidepressant use

By Rhoda L. Fisher, PhD

It is the responsibility of clinical practitioners to be aware of and to apply the best validated scientific findings pertinent to their work. So why are psychiatrists prescribing antidepressants for children and adolescents when the scientific data conclusively contradict such a practice?

Until about 20 years ago, the medical establishment did not recognize depressive symptomatology in children and adolescents; therefore, according to the experts, they were never pathologically depressed. No one knows why this changed, but in recent years increasing numbers of youths have been diagnosed as depressed.

With the arrival of psychotropic drugs for adults, it was not hard to take the next step and extend the administration of antidepressant drugs to children and adolescents following the "discovery" of this pathological state in our youth.

But how effective are antidepressants for this population? Although it is generally accepted that there should be a scientific rationale for medical treatment,

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Inside This Issue

Toilet training research bares toddler's number one preference. *See page 3*

Teens with OCD and tics have more severe obsessions than those without tics. *See page 3*

Abused PTSD children have sleep problems by night, hyperactivity by day. *See page 4*

Coming next month:
Author and children's librarian Kathleen Odean recommends books about girls who face challenges in untraditional areas.

This month's client handout
Does my child need an antidepressant?

PS 026390

But is it ethical to withhold treatment to which some children respond?

By William Fishbein, PhD

Recent writings by Rhoda Fisher, PhD, and her late husband, Seymour Fisher, PhD, are creating an uproar in the field of child pharmacotherapy.

The critical importance – and implications – of these papers for clinical treatment of tens of thousands of prepubescent and adolescent children, in the United States alone, suffering from non-psychotic major depressive disorder, demands a careful scrutiny of the authors' claims.

Major depression, using virtually the same criteria used for adults, is unquestionably diagnosable in children. Both major depression and dysthymia in prepubescent children and adolescents are associated with high rates of recurrence, chronicity and psychosocial dysfunction.

Despite the conclusive evidence that child and adolescent depression resemble the symptoms of depression in adults, only a small number of double-blind placebo-controlled studies have examined the efficacy of antidepressant treatment in these groups. The first of these scientific studies were primarily confined to the tricyclic antidepressant class of drugs.

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The Brown University **Child and Adolescent Behavior Letter**

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Keep Your Eye On

... a new drug for pediatric AIDS.

A new drug in the battle against pediatric AIDS from Roxanne Laboratories appears to have potential benefit in preventing transmission of HIV from mother to child during labor and delivery. During a recent study of eight babies, mothers were given a dose of Viramune during labor, and then each infant received a dose between 48 and 72 hours after birth. Pyruvate kinase (PK) analysis showed that this regimen kept the therapeutic level of the drug in infants throughout the first week of life without toxicity to mother or child. A second study also showed sustained antiviral efficacy using triple therapy including Viramune in infected infants between 2 1/2 and 6 months of age. Viramune is currently in use for HIV-infected adults who have experienced clinical and/or immunologic deterioration. For more information on Roxanne Laboratories' expanded access program, call 1-800-595-5494.

... the web.

The American Academy of Pediatrics (AAP) now can be found in cyberspace at its new website, http://www.pediatrics.org. The new electronic pages will offer online classified advertisements, hyperlinks for extended navigation, search capabilities and previews of upcoming issues of the AAP journal, *Pediatrics*.

... handwriting proficiency.

Preschoolers who use their hands often to manipulate small objects such as puzzle pieces may end up with better handwriting skills, new research in the *American Journal of Occupational Therapy* suggests.

A study of 48 first-grade students found that those who scored best on a test of in-hand manipulation skills were also more likely to be identified as having the best handwriting.

"These results suggest that early practice with a pencil or crayon may not be the best way to teach a child how to use a writing instrument," says Jane Case-Smith, co-author of the study and associate professor of occupational therapy at Ohio State University.

The participating first-graders took three tests thought to influence proficiency in handwriting: an in-hand manipulation test; a visuomotor integration test (how well a child visually interprets a shape drawn on paper and copies it him- or herself); and an eye-hand coordination test. Results showed that the manipulation and visuomotor integration tests were associated with good handwriting, but the eye-hand coordination test was not.

"Introducing young children to writing instruments is fine," says Case-Smith. "But it shouldn't be the focus of their play or their activities in a preschool. Proficiency in writing should follow once a solid foundation of manipulation skill is established."

BEST COPY AVAILABLE

... delinquent girls.

The number of juvenile court cases involving girls increased more in relative terms between 1989 and 1993 than did the number of cases involving boys, according to statistics from the U.S. Department of Justice. The total number of delinquency cases involving girls increased by 31 percent, while cases involving boys increased by 21 percent. Growth in the delinquency caseload was greater among girls in cases involving person and property offenses. By contrast, the number of cases involving drug law violations and public order offenses increased more among boys.

... ADD treatment.

A brain scan that uses only minute amounts of radiation may help doctors pinpoint the best medication to use for children with attention-deficit disorder (ADD) and ADD with hyperactivity (ADHD). Researchers at the annual meeting of the Radiological Society of North America say the use of single photon emission tomography (SPECT) may allow earlier treatment for these problems, while screening out drugs that may not work effectively.

"The children are often referred to psychiatrists after they do not respond to the common ADD and ADHD medications prescribed by their pediatricians," says University of Texas-Houston Medical School psychiatrist Guruswami Ravichandran, MD. Brain SPECT testing allows a fine-tuning of therapy that helps physicians identify more appropriate medications, he says.

"Patients often have other disorders, such as seizures, learning disabilities, violent behavior or depression, that do not respond to (stimulant medicines)," adds Lank M. Lamki, MD, Ravichandran's colleague. "To find the appropriate treatment, psychiatrists now test different medications in eight- to 12-week cycles. By using SPECT we may be able to help them avoid this trial-and-switch period and ascertain the right medication sooner and with greater accuracy."

SPECT uses a computerized gamma camera that takes three-dimensional pictures of the patient's brain based on how the tissue takes up the isotope. The resulting images provide exact measurements of areas with decreased blood flow, indicating specific mental conditions. *(Reuters)*

What's New in Research

Study bares preferences in potty training

It appears the nation's toddlers have made clear their number one preference when it comes to using a potty chair or toilet for the first time. One in five toddlers will use the facilities for urinating but not for moving their bowels. That move comes almost a month later for many tots, a researcher learned in a recent study at the University of Pennsylvania School of Medicine. It is the first large-scale study in 30 years to look at toilet-training behavior. The author looked at 482 healthy toddlers between the ages of 18 and 30 months and found that 60 percent of the toddlers were trained by age 3. Boys held out a little longer than girls, with 48 percent of boys not trained until after 3 years of age, compared to 30 percent of girls. Bruce Taubman, MD, author of the study, reported that 59 percent of the boys were at least 2 years of age when introduced to the potty, compared to 41 percent of girls. Only small percentages of toddlers train on the early and late side (4 percent of the children were trained by age 2; 2 percent were still not trained at 4 years old). He concluded that the age at which a child was toilet-trained was not associated with the child's behavior score or whether he or she attended day care, had siblings or a mother who worked.

In a related study at the University of Pennsylvania School of Medicine and Children's Hospital of Philadelphia, researchers found that children who refused to move their bowels in a potty chair or toilet do not have more behavior problems than children who are toilet-trained.

"Toilet training and toileting refusal for stool only: a prospective study," B. Taubman, MD, *Pediatrics*, 99(1):54-58, 1997. For reprints, write Dr. Taubman, 2041 Naudain St., Philadelphia, PA 19146. "Behavioral characteristics of children with stool toileting refusal," N. J. Blum, MD, et al., *Pediatrics*, 99(1):50-53, 1997. For reprints, write Dr. Blum, Children's Seashore House, 3405 Civic Center Blvd., Philadelphia, PA 19104.

Teens with OCD and tics prone to aggressive images

Adolescents diagnosed with obsessive-compulsive disorders (OCD) that include tics are more prone to aggressive and sexual images and obsessions than are adolescents without tics, according to a recent study. The 40 adolescents in the study were part of a larger sample screened at age 17 as part of the physical examination for the Israel Defense Force. The group with OCD and tics was predominately male, with a ratio of 14 to 1. The authors note that further analysis is needed to see if gender affects presentation of the OCD disorder.

Even with relaxed inclusion criteria to include sub-clinical OCD and symptoms and all motor and vocal tics, the authors conclude that adolescents with OCD and tics have symptoms "that are richer in violent impulses and images" than those without. In the adolescent sample, those with OCD alone had more sexual ideation and seemed to experience their obsessions and compulsions as more severe.

"Obsessive-compulsive disorder with and without tics in an epidemiological sample of adolescents," A.H. Zohar, PhD, et al., *American Journal of Psychiatry*, 154(2):274-276, 1997. For reprints, write Dr. Zohar, Scheinfeld Center for Human Genetics in the Social Sciences, Department of Psychology, Hebrew University, Jerusalem, Israel 91905.

Hyperactivity prevalent in abused children

Abused children with posttraumatic stress disorder (PTSD) may be hyperactive by day and sleepless by night, according to researchers at McLean Hospital. The findings may be important in making differential diagnoses in children who are referred for psychiatric conditions such as attention-deficit/hyperactivity disorder (ADHD) or depression. The clinical study compared the sleeping patterns and daytime activity of 19 unmedicated children ages 6 through 12 who had suffered documented abuse with those of 15 healthy children. According to the study, sleep problems of the abused children were more profound than those of depressed children. Early onset of abuse was also linked to development of PTSD and hyperactivity. Researchers conclude that abuse history should be taken into consideration when diagnosing ADHD or depression.

"Relationship between early abuse, post traumatic stress disorder and activity levels in prepubertal children," C.A. Glod, PhD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10):1384-1393, 1996. For reprints, write to Dr. Glod, Developmental Biopsychiatry Research Program, McLean Hospital, 115 Mill St., Belmont, MA 02178.

Resources

Infancy Institute features workshops, courses

More than 30 workshops on working with infants, toddlers and their families will be featured as part of the 10th annual Infancy Institute June 25-27 at Bank Street College of Education in New York City. Keynote addresses will be given by Carolee Howes, PhD, on "The Importance of Relationship," and Samuel Meisels, EdD, on "Exploring the Relationship between Infant, Assessment and Intervention."

A separate pre-institute, one-credit course will be offered on June 23 and 24 for those interested in teaching about infants and toddlers at the college level. For the program brochure, call the Infancy Institute at (212) 875-4728.

Guide explains how to set up a teen court

The American Probation and Parole Association (APPA) has developed a publication to help juvenile justice agencies develop programs that are philosophically sound and legally defensible. *Peer Justice and Youth Empowerment: An Implementation Guide for Teen Court Programs* provides program organizers with a general overview of issues to consider and leads them through the decision-making process for implementing a teen court program tailored to local needs.

The guide covers legal issues, case management practices, financial resources and program evaluation, and describes two teen court models. Co-published by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and other federal agencies, the guide was developed as part of APPA's Teen Courts Project, which provides training and technical assistance to teen court programs. For a free copy of *Peer Justice and Youth Empowerment*, call OJJDP's Juvenile Justice Clearinghouse at (800) 638-8736. To find out how to get training and technical assistance for teen court programs, contact Tracy Godwin, teen courts project manager, at APPA, c/o the Council of State Governments, PO Box 11910, Lexington, KY 40578-1910, or send her a fax at (606) 244-8001.

Educators' guide published for adolescent parents

What educators can teach young parents about becoming good parents is the topic of a new curriculum from Cornell University. *Teens as Parents of Babies and Toddlers: A Resource Guide for Educators* is a 220-page curriculum for educators to use in developing classes and workshops for teen parents to try to prevent the potential negative effects of adolescent parenthood.

Topics include identifying support networks, dealing with stress and crises, controlling violence, infant and toddler development, feeding, understanding temperaments, play activities, discipline, difficult babies, separation issues, health and safety activities.

Jennifer Birckmayer, a human development specialist in the department of human development and family studies at the New York State College of Human Ecology at Cornell, is the first author. *Teens as Parents of Babies and Toddlers* costs $25, including shipping and handling. Copies are available from the Cornell University Resource Center, 7BTP, Ithaca, NY 14850.

Does my child need an antidepressant?

Some kids have been helped by medication, and maybe even diverted from a future of chronic depression, but most of what doctors know about antidepressants in the human body comes from studies of adults.

It seems like everyone's on Prozac nowadays. But a little kid? Come on, he's only 9. How can a kid be depressed anyway?

Deciding whether or not your elementary school-aged son or daughter should take an antidepressant medication is striking an uneasy balance between the risks of depression and the risks of treatment. If your child has been diagnosed with depression, he or she has a serious disorder that becomes chronic in many untreated children. But the medications prescribed for depressed adults — based on hundreds of research studies — are comparatively unstudied in children.

Until a recent study at the University of Texas Southwestern Medical Center showed Prozac to be superior to placebo in a group of severely depressed 7- to 17-year-olds, the research on antidepressants for kids has been disappointing.

The big question remains: Do they work?

"It's a simple question with a pretty complicated answer," says child psychiatrist Hugh F. Johnston, MD, an associate professor of psychiatry at the University of Wisconsin and director of the university's Child Psychopharmacology Information Center.

Just because a study fails to show a difference between patients who take a medication and those who take a sugar pill doesn't necessarily mean that the drug is worthless. If a study of fever didn't account for its underlying causes, Johnston explains, researchers wouldn't find a treatment effect for penicillin because most fevers are caused by viruses, which are unaffected by penicillin. "If you concluded that penicillin is no good for anything, that would be a big mistake," he says. "Because the earlier studies of antidepressants in kids fail to find an effect, many clinicians have concluded that they don't work. I think that's very, very unlikely. I think the truth is that they do work, but they certainly don't work for everybody."

Predicting which kids will get better on which medicine is a blend of art and science that begins with a diagnosis. But until recently, depression was thought to afflict only adults. "In the late '70s, major journals said children and adolescents just don't get depressed," says Carroll W. Hughes, PhD, a professor of psychology at the University of Texas Southwestern Medical School in Dallas and one of the researchers involved in the Prozac study. "Now clinicians would say, 'Of course children and adolescents get depressed. Everybody knows that.' But it didn't used to be that way."

It's now known that major depressive disorder can happen in kids as early as preschool as well as in elementary and secondary school. Children are diagnosed with depression pretty much the way adults are: by the way they say they feel. The observations of kids' parents and teachers are also helpful in determining the nature of the symptoms. In adults, the main symptom of depression is a persistent depressed mood, and of mania, a persistent elevated mood. But in children, both of these mood disorders can manifest as an irritable or angry mood.

"Younger kids tend to externalize," Johnston says. "A 28-year-old and an 8-year-old with depression both feel terrible. The 28-year-old is likely to say, 'There's really something wrong with me,' but the 8-year-old is much more likely to say, 'My parents and my teachers are all jerks.' From the child's perspective, that's a realistic view of the world. And that, of course, leads to hostility and irritability and anger."

That the 8-year-old patient has different symptoms than the 28-year-old's doesn't surprise Hughes, who is also chief of psychology at Terrell State Hospital in Texas. "When you think neurodevelopmentally, why would you expect them to be the same? They're

continued ...

not the same. The brain's not the same; the neuroendocrine system's not as developed in the same way at that stage. Some of us wonder if it isn't a developmental process."

Children aren't just small versions of adults. Their faster metabolisms may call for higher doses of medication, proportional to their body weight, than adults take. Or they may have to take more frequent doses to maintain a consistent level of medicine in their blood.

"There is a tendency for many clinicians to undertreat children," says Johnston of the University of Wisconsin. "They look at a child who's half the size of an adult and figure, 'We'll use half the dose.' I think a good clinical rule is to use approximately the adult dose or slightly less for most kids."

Johnston cautions that metabolic rates vary with each child, and sometimes the dose will need adjustments. Dosing is as tricky as diagnosing, with the goal of finding the dose that produces the greatest improvement with the fewest side effects. Antidepressant side effects vary depending on the medication, the dose and the individual. Medications belonging to a class called the *tricyclics*, such as imipramine and nortriptyline, can cause dry mouth, blurred vision, drowsiness, lowered blood pressure and constipation. Another type of antidepressant, the *selective serotonin reuptake inhibitors* (SSRIs), which include Prozac and Paxil, can cause agitation, nausea and loss of appetite. Some children taking SSRIs, particularly younger children, become disinhibited, saying and doing things they wouldn't have before. "That can be a limiting factor in treatment," Johnston says, adding that the change can also be more subtle. "Sometimes it can almost seem positive. A kid who's withdrawn and in a shell is now more extroverted," he says. "The boundary between positive effects and what you'd call side effects is a little bit blurry at times."

With some exceptions, kids seem to have side effects at the same frequency as adults, and maybe less.

It can take a while for an antidepressant to kick in, usually three to six weeks. Once the child is on a medication at a dose that works, parents and doctors have to make another decision: How long should he or she stay on it? Some doctors prefer that patients with chronic or relapsing depression continue to take medication as a preventive measure. But although these antidepressants have been in use for years, whether they have long-term negative consequences remains to be seen.

"No one really knows what the implications are developmentally for kids on antidepressants for years. There's no theoretical reason to think that it's bad, but no one really knows for sure," Johnston says. "On the other hand, being depressed for years does have developmental implications that are pretty clear: Kids don't develop social skills, they don't achieve in school, and their options for their future become narrowed.

"It's a tough call, and it has to be made on a case-by-case basis." ■

The Brown University **Child and Adolescent Behavior Letter**

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Media Policy

Pediatricians say TV ratings should label content, not viewers' age

Content ratings for sex, violence and strong language, not age groups, should be the basis for effective television ratings, according to the American Academy of Pediatrics (AAP).

"Content-based systems, such as those developed by the Recreational Software Advisory Council (RSAC) and the cable system, are effective in helping parents make informed decisions about the program selections," the academy said in a statement issued in response to the television industry's effort to institute program labeling similar to the movie industry's.

Long an advocate for parental supervision of what kids see on television, the AAP says that next to the family, the television is the most important influence on child development and behavior in American society.

By age 18, the average teen is estimated to have spent more time in front of the tube than in front of a classroom teacher. That same teen will see an estimated 14,000 sexual references and innuendoes per year on television, yet only 150 references to sexual responsibility, abstinence or contraception, the AAP reports. ■

Antidepressants

from page 1

the application of this concept is complex and overlaid with ambiguity. As an aside, it is interesting to note that once the U.S. Food and Drug Administration approves a drug, physicians can prescribe it for any condition they wish. Our courts have always left drug treatment to physicians' "best judgment." This really means that prescribing physicians do not need any scientific proof that a particular drug is effective for the patient they have in mind to treat. Nor do they need even to have the dosage experimentally verified.

Reports have it that literally millions of depressed children are being treated with antidepressants. In 1993, the *New York Times* reported that 4 to 6 million prescriptions for desipramine (Norpramin, Pertofrane) had been issued for children 18 years old and under in the previous year. Among other frequently prescribed drugs are imipramine (Tofranil) and fluoxetine (Prozac). Some textbooks even recommend such use of antidepressants and offer detailed procedural advice.

A survey of the literature offered up a total of 13 pertinent, double-blind studies. These make up what is totally available to test the efficacy of antidepressants for children and adolescents. Not one of these studies demonstrated that antidepressants proved to be more therapeutic for childhood or adolescent depression than are placebos. A few studies actually suggested that the placebo was more successful than the active drug, and it was not possible to find any body of data that demonstrated that antidepressants were more therapeutic than were placebos.

> *Not one of these studies demonstrated that antidepressants proved to be more therapeutic for childhood or adolescent depression than are placebos.*
>
> **— Rhoda L. Fisher, PhD**

One typical negative review concluded: "To date, none of the placebo-controlled, double-blind studies of tricyclics in depressed prepubertal children have found drug therapy to be superior to placebo ... Equally discouraging are the findings from drug studies of depressed adolescents."

Another notes: "A literature review of the use of tricyclic antidepressants in children and adolescents with major depression found them to be clinically effective in several open studies, but no double-blind placebo-controlled study reported that tricyclics were superior to placebo."

Still another research group concluded: "The empirical data reviewed does not support antidepressant efficacy in child or adolescent major depressive disorder, neither when results are collated nor when the few double-blind placebo-controlled studies are reviewed individually."

As an example of the double-blind antidepressant experiments, here is a brief description of one of the more frequently quoted. In 1992, a research group conducted an experiment using nortriptyline (Pamelor) as the experimental drug. To begin with, subjects were all put on placebo for two weeks as preliminary to the real experiment. All those who improved on the placebo were then dropped from the experiment. Starting with a population of 62, 12 were dropped from the experiment because they improved on the placebo during the preliminary phase.

The experiment itself was then begun with 26 experimental subjects who were given nortriptyline, and 24 control subjects, who were given a sugar pill. After 10 weeks, the results indicated no differences between the two groups.

These consistent negative findings have been widely described in various journals. However, even in the face of such dramatic data, antidepressants for children and adolescents are still widely prescribed. But the practice is not without consequences.

What has added to the urgency of recognizing and doing something about this dilemma has been scattered reports that children receiving antidepressants may die suddenly and unexpectedly. Antidepressants also cause adverse side effects that, although not fatal, may cause considerable discomfort.

In view of their negative side effects and clearly demonstrated lack of therapeutic effectiveness, it is inappropriate to treat the younger segment of the population with antidepressant medications. Indeed, I would assert it to be unethical to refer children or adolescents for antidepressant drug treatment. ■

See also, "Antidepressants for children: Is scientific support necessary?" Rhoda L. Fisher, PhD and Seymour Fisher, PhD, *Journal of Nervous and Mental Disease*, 18(2):99-102, 1996.

Rhoda L. Fisher is a clinical psychologist in private practice and a member of the NYSPA.

Is it ethical?

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These studies uniformly lack evidence demonstrating the efficacy of tricyclics in children, unlike studies of adults. Yet anecdotal stories and open studies predominantly showed that, like adults, many young patients respond to antidepressant medication. The reason for the marked difference between child/adolescent antidepressant studies and adult studies still remains unclear. More recent studies, however, especially employing the serotonin specific reuptake inhibitor (SSRI) class of drugs, have shown them to be an effective antidepressant in prepubescent and adolescent children (see box to the left).

Study finds Prozac better than a placebo

A recent study of fluoxetine (Prozac) in children and adolescents found fluoxetine to be superior to a placebo in the acute-phase treatment of major depressive disorder in child and adolescent outpatients with severe, persistent depression.

A total of 96 child and adolescent (ages 7 to 17) outpatients with non-psychotic major depression (stratified for age/gender) were included. After three evaluation visits, half were randomized to 20 mg fluoxetine and half to a placebo. Following randomization, they were seen weekly for eight consecutive weeks. Primary outcome measures were the global improvement of the Clinical Global Impressions (CGI) and the Children's Depression Rating Scale - Revised (CDRS-R), a measure of depressive symptom severity.

At the end of the study, 56 percent of those on fluoxetine and 33 percent on a placebo were rated "much" or "very much" improved on the CGI. Significant differences were also noted in weekly CDRS-R ratings after five weeks of treatment. Equivalent response rates were found for subjects 12 years old and younger and those 13 and older. However, complete symptom remission occurred in only 31 percent of fluoxetine-treated and 23 percent of placebo-treated subjects.

The authors say the response rates were similar to those of adult outpatients with major depression using comparable analyses.

"A double-blind, randomized placebo-controlled trial of fluoxetine in depressed children and adolescents," Graham J. Emslie, MD, et al., *Archives of General Psychiatry* (in press). For reprints, contact Dr. Emslie, Department of Psychiatry, U.T. Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75235-9070.

The first troubling aspect of Rhoda Fisher's statement is that the articles to which she refers, both the one above and that published in the February 1996 *Journal of Nervous and Mental Disease*, are actually a series of editorial comments on appraisals of the antidepressant (12 of 13 studies use tricyclic) research of various other writers, none of whom are authors of the original published studies. There is neither systematic analysis nor a summary of the results of the individual experiments. But the opinion is tendered as fact.

Tangentially related to the above point, yet pertinent to the assessment of the article, the authors routinely make inflammatory remarks and belittling comments about child psychiatrists and the medical community. For instance, Fisher states, "What has added to the urgency of recognizing and doing something about this dilemma has been scattered reports that children receiving antidepressants may die suddenly and unexpectedly.”

She provides no qualification or explanation of this profoundly disturbing remark about the tragic deaths of four children. Only one drug has actually been implicated in the deaths – desipramine (Norpramin, Pertofrane) – not all antidepressants, as Fisher would have the reader believe. However, a relationship between desipramine, or imipramine (Tofranil) (desipramine is the active metabolite of imipramine), ingestion and the deaths has never been established by any authority. The four prepubertal children who died were found to have been taking appropriate doses of the medication. They were also found to have nontoxic blood levels. Had Fisher added a brief qualifier, it would have been sufficient to indicate her concern about the use of desipramine or imipramine, without creating panic in the minds of parents whose children use antidepressants.

It has been known for some time that elderly people and prepubescent children are more sensitive to tricyclic side effects, including medication-induced constipation and especially cardiac changes, than are young adults. To minimize the possible side effects, it has become the norm to obtain an electrocardiogram (EKG) in children taking tricyclics. EKGs are typically taken before treatment, after major dosage changes, and if higher than usual doses are prescribed. In any event, almost no one uses desipramine in children and adolescents anymore. SSRIs are now the first-line drugs for the treatment of affective disorders in adults, adolescents and prepubertal children.

Finally, Fisher has made a profound fundamental error in a statistical assumption that most students of the scientific method have learned. She takes the position that failure to demonstrate the efficacy of antidepressant medication over placebo provides support for the contention that the drugs are ineffective agents for treating major depression.

Intuitively, this may seem like a reasonable conclusion even though it is, to remind the reader, a logical impossibility to prove that the null hypothesis is true. However, findings of no differences – those that would lead to acceptance of the null hypothesis – are especially critical in applied research when falsely accepting the null hypothesis involves more than a theoretical issue, but may involve life-and-death consequences.

Given the strong inverse association between brain serotonin levels and suicide – the second leading cause of death in adolescents 15 to 19 years of age – *failing* to provide antidepressant medication to treat young depressed patients could lead to tragic consequences.

The findings of the double-blind placebo-controlled studies do not “contradict” the use of antidepressants in children: They simply do not provide support for their use. This is an important distinction. It implies that more research needs to be undertaken to either improve assessment of the tricyclic antidepressants, develop alternative drugs as has happened with the development of the SSRIs, or advance functional treatments with proven cost-effectiveness. At the same time, considerable caution needs to be exercised before abandoning a treatment that most likely has saved untold lives. ■

William Fishbein is professor of psychology at the City College and Graduate School, City University of New York and a member of the NYSPA.

Recommended Reading

Primary Prevention Works – *Thomas Gullotta, and George W. Albee, Sage, $27.95 (paperback); $54.95 (hardcover), (805) 499-9774 or order@sagepub.com.*

The National Mental Health Association (NMHA), working with mental illness prevention leaders Albee and Gullotta, has released this compilation of 14 award-winning mental illness prevention programs from across the country. The book demonstrates how the programs have positively touched the lives of children and families, and how these same programs can be implemented in other communities.

“With so many pressing problems confronting children and families in America, we must act now to begin to reduce the tragedy of needlessly wasted lives,” former first lady Rosalynn Carter writes in the book’s forward.

Gullotta, CEO of the Child and Family Agency of Southeastern Connecticut, and Albee, professor emeritus at the University of Vermont, compiled the programs from winners of the NMHA’s Lela Rowland Prevention Award. Established in 1978, the Rowland award is given annually to programs judged to be among the most effective prevention efforts in the United States.

Although mental disorders cost $72.7 billion each year in treatment, related support and lost productivity, funding for prevention programs has been inconsistent, due in large part to a lack of confidence in the effectiveness of specific prevention programs.

“It is our hope that Primary Prevention Works will serve as both a catalyst and a how-to manual, resulting in community implementation of quality mental health prevention programs during this era of contracting government and volatile funding,” said NMHA president and CEO Michael M. Faenza, MSW.

Commentary

How some youths are attempting change

By John de Miranda

Shayla, Romeario, Dante, Garesa and Demetreus have several things in common. They are high schoolers, ages 16 and 17, and live in some of Chicago's toughest neighborhoods. They are team leaders of YOUTH POWER, a youth-centered prevention and empowerment program of "Just Say No" International. They are African-American, and they all expect to be successful adults. Their career plans include psychologist, criminal defense attorney, chef and engineer.

Their local YOUTH POWER teams are supported by a high-risk youth grant from the federal Center for Substance Abuse Prevention. They come together once a month and participate in a group they call Youth Leaders of Chicago.

I met with these youths last month to hear their views on issues facing our nation. Our "focus group" touched on such subjects as increases in substance use, quality education, community violence and relations between adults and youth.

I first asked how easy it is to get alcohol and illicit drugs. They burst out laughing. Access begins at 7 a.m. in the school bathrooms. "You can't walk by without getting hit in the face with the smell of weed." "By the time it's lunch many kids are high and hungry."

> *"We need good, strict teachers. I wish our country would invest more in schools. There's a big, big hole in the bathroom ceiling."*

They charge that a major source of supply is low-wage guards who maintain school security. Even some teachers make drugs and alcohol available. But drug testing is not the answer, they say. "Kids who use drugs would just stop coming to school. It would make things worse."

This group is angry about the conditions they face. "We need good, strict teachers. I wish our country would invest more in schools. There's a big, big hole in the bathroom ceiling."

They are very aware of changes to the welfare system. "Welfare reform means more criminals, more people in jails. People will have to steal for food. We need jobs, especially summer jobs. I wish Bill Clinton would spend a night in the projects – you can smell the violence."

They believe many adults have abdicated their responsibilities. "Why are adults so afraid of kids? Gangs aren't all bad. Gangs help protect the community from other criminals. Right now there's a peace on; things are pretty cool."

These kids remain hopeful about the future and grateful about their participation in YOUTH POWER. "I like the challenge. When I hear people doubting my abilities, it makes me want to rise up and do it. Other programs have adults telling you what to do. We get to make the decisions and do the work. This kind of program ought to be available to kids everywhere."

Chief Leroy O'Shields of the Chicago Housing Authority's police department has asked Youth Leaders of Chicago to be an advisory group to the department. "I would like the watch commanders of each development to have regular contact with the YOUTH POWER team from that development," says O'Shields, a champion of community policing. "These young people can perform an immeasurable service."

I asked the group for one thought they would like to share with the country. To young girls: "If they love you, they will wait." To our government leaders: "Better schools help kids. Make college more accessible." To fathers: "Stand by your children."

John de Miranda is vice president for program services at "Just Say No" International, 2000 Franklin St., Suite 400, Oakland, CA 94612; phone (510) 451-6666 or 1-800-258-2766; fax (510) 451-9360; or e-mail john@justsayno.org. For more information about Youth Leaders of Chicago, contact Marta Bailey, regional director of "Just Say No" International, 120 S. Riverside Plaza, Fourth Floor, Chicago, IL 60606; phone (312) 930-0011.

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Gender Issues

In fiction as in life, girls should be encouraged to take on challenge

By Kathleen Odean

In the world of children's books, girls have traditionally been rewarded for being passive and obedient. While boys had adventures, girls stayed home, learned to be good and were sometimes "rescued" by princes. Exciting stories about sports, business and leadership have typically been the exclusive realm of boys.

In real life, girls are still being "rescued" in the sense that adults are more likely to perform tasks for a girl than for a boy, depriving the girl of the chance to make mistakes and learn from them, and maybe master a new skill.

Fortunately, the last 10 years have produced a number of exciting stories about girls who face challenges in untraditional areas, going through the process of taking risks and gaining self-confidence through increased competence. They perform tasks themselves, instead of being rescued.

As girls get more involved in athletics, books are starting to reflect this new participation. The 20 books described here, both fiction and nonfiction, portray girls in these active roles. These stories show the rewards of becoming stronger and more

> ***These stories show the rewards of becoming stronger and more physically active, a healthier way for girls to view their bodies than the more common emphasis on beauty and thinness.***

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Inside This Issue

Children interested in math and science may do better studying piano than computer.
See page 5

Far too little is known about the safety and efficacy of antipsychotics for children.
See page 5

Artificially conceived twins are more likely to have low birth weight.
See page 5

Coming next month:
Prenatal cocaine exposure and child outcome: What do we really know?

This month's client handout
Bibliography for risk-taking girls in children's books

Family Matters

Pipher advises parents to turn off appliances, tune in to family

By Lu Cribari, Associate Editor

Mary Pipher, the straight-talking guru of family therapy, says it's time Americans turned off their appliances and tuned in to each other.

Speaking to an audience of nearly 500 in Rhode Island recently, Pipher, a psychologist from Lincoln, NE, stands with one hand on her hip and delivers her message in a steady Midwestern accent. The message is steeped in a personal history of grandparents who homesteaded on the plains of eastern Colorado, and of raising her own family in Lincoln with her husband, Jim, also a psychologist. She has become a regular on the lecture circuit after her first book about adolescent girls, *Reviving Ophelia*, rose to national prominence. But she rejects the notion that she has become a public person. She is a storyteller.

Pipher comes from a family rich with stories, and she retells them to audiences around the country because she says family stories give hope — an ingredient much needed in today's society. Her most recent story is the subject of a new book, *The Shelter of Each*

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Psychology 101

Professor's crash course is college students' dream

Catching some ZZZs is as important as learning your ABCs — and may even help you learn better, says sleep researcher James B. Maas, a professor of psychology in Cornell University's College of Arts and Sciences.

He's so sure of it after 34 years of teaching that he devotes the first three and a half weeks of his popular introductory class in Psychology 101 to the importance of sleep.

Not that his class is a sleeper. Some 1,300 students line up for it each semester, making it the school's largest class offering. It's no wonder, with a standing homework assignment to nap and get more sleep.

If this sounds like a college student's dream come true, don't nod off.

It's really more of a wake-up call to the drowsy, reports Maas, who cites recent findings from one study showing that a college-age student who drinks one beer on five to six hours of sleep is just as impaired as a person who drinks a six-pack but has eight hours of sleep under his belt.

Maas tells students that coming to class with barely six hours of sleep is "the equivalent of lighting a match to $80," the amount he estimates it costs parents to pay for a day in the average college classroom.

He recommends going to bed at the same time on weekends and weekdays. Long an advocate of the "power nap," — in fact, he coined the term — Maas says if you can't get good nocturnal sleep, take a 15- to 20-minute nap.

The lesson for college students is to change their habits, says Maas.

Apparently, many of his Psych 101 students catch on quickly, according to a survey conducted last fall of 802 of his undergraduates, who reported that as a result of what they learned in Maas's class, 30 percent were getting more sleep each night and 23 percent said they were now napping more frequently from one to four times a week.

Maas discusses the details of three decades of sleep research in two new books, *The Power of Sleep: Preparing the Mind for Peak Performance*, and a second volume co-authored with Stanford University sleep researcher William Dement, MD, tentatively titled, *The Stanford-Cornell Sleep Book for College Students.* Both are in the discussion stage with publishers, he says.

An award-winning professor and collaborator on a PBS prime-time special on sleep, Maas says he's probably "one of the few professors in the world" who doesn't really mind if he catches a student napping in class — though he would consider it a personal challenge to find out why. He never teaches too early in the morning or too late in the afternoon. Psych 101 is scheduled for 10 to 11 a.m. ■

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Keep Your Eye On

... free clinics and teens.

High school students with access to free public health clinics are more likely to seek treatment for sexually transmitted diseases (STDs), use birth control and decrease their use of marijuana and tobacco, according to an article in *The Monitor*, published by the American Psychological Association. The findings came out of a study of 2,000 inner-city high school students in Chicago during 1993 and 1994 in which investigators from DePaul University compared students who had access to clinics to those who did not. The research team also found that it was able to identify symptoms of depression in 46 percent of the teens who sought help in the free clinics. Because clinic workers have enough access to the students, they are able to observe signs of trouble and intervene appropriately, according to investigators. *(The Monitor*, January 1997)

... reptilian risks.

Warning: Iguanas may be hazardous to your health. According to a study in *Pediatrics*, the journal of the American Academy of Pediatrics, owning these critters may put children at risk for salmonella infection. Authors of the study found that there had been an increase in reported salmonella serotype Marina infections from one case in 1989 to 67 in 1995. This corresponds to increases in iguana importation, the journal reports. (*Pediatrics*, March 1997)

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... STD awareness.

April is STD Awareness Month, and the American Social Health Association is urging sexually active people to use condoms to reduce their risk of acquiring STDs. The association points out that young people are at highest risk for all STDs. An estimated two-thirds of the 12 million new infections in the United States each year occur in people under 25. One out of four of those new cases are in teenagers. Sexually transmitted diseases, chiefly chlamydia and gonorrhea, are often associated with pelvic inflammatory disease, which is blamed for 15 percent of all infertility cases in American women, the association reports.

... classroom 'filler.'

Two recent studies at Johns Hopkins University and Vassar College have given poor marks to the commercially produced, in-class television news program that is broadcast to 8 million students in 12,000 schools across the nation. A spokesperson for *Channel One* claims that schools are pleased with the programming and that 99 percent of the schools renew their contracts. Schools receive free televisions, VCRs, wiring and a satellite link in exchange for airing the program. Professor John Crispin Miller of Johns Hopkins, in a paper titled "How to Be Stupid: The Teachings of Channel One," wrote that the programming was "no more than filler ... to get students ready for the ads." William Hoynes of Vassar found that only 20 percent of the content was related to current issues. Advertising, sports, weather and natural disasters made up the other 80 percent. (*School Board News*, February 1997)

... alternatives that pay off.

Alternative-education centers for adolescents appear to have a lot going for them even though the students bring multiple problems with them into the classroom, a recent survey indicates. The survey by the Minnesota Department of Children, Families and Learning shows that students in alternative centers are twice as likely as students in traditional classrooms to say teachers show respect for them, and their positive reactions extend to fellow students as well, according to a release from the Minnesota Department of Human Services. The study comparing students in alternative and traditional settings recommends building on positive relationships between students and teachers.

... an ounce of prevention.

We are getting heavier and so are our children. Researchers at the Centers for Disease Control and Prevention and Tulane Center for Cardiovascular Health, who examined more than 11,000 participants between the ages of 5 and 24 over two decades, found a twofold increase in overweight participants between 1973 and 1994. In the final two years of the study, researchers found that among the 5- to 14-year-old age group, there was a 31 to 37 percent increase in those who would have been considered overweight by 1973 standards. The authors concluded that there is a need for prevention at an early age, since overweight children tend to become overweight adults. (*Pediatrics*, March 1997)

... students and steroids.

A new and aptly named program called ATLAS (Adolescents Training and Learning to Avoid Steroids), aimed at discouraging use of anabolic steroids, appears to be a winning formula for coaches and high school athletes, according to results of a National Institute on Drug Abuse (NIDA) study conducted by scientists at Oregon Health Sciences University.

The yearlong study, the first to use coaches as part of a drug prevention team, found that student athletes who participated in the program ended up with a better understanding of the effects of steroids and personal vulnerability to the consequences of steroid use than did those not in the program.

The ATLAS program involves seven 50-minute sessions led by coaches and student team leaders and focuses on the effects of steroids, sports nutrition and strength-training alternatives. To measure effectiveness, students were asked to fill out confidential questionnaires before the program and one year after participating. Researchers reported that participants had less belief in media messages promoting steroid use and a greater belief in the team as a source of information. Overall, ATLAS participants reported improved perception of athletic abilities and strength training self-efficacy; improved nutrition and exercise behaviors; reduced intentions to use steroids; and improved drug-refusal skills.

For more information, call (301) 443-1124, or visit the NIDA website at http://www.nida.nih.gov. (*The Nation's Health*, January 1997)

... breaking the poverty cycle.

Acquiring good language skills, staying away from smoking and avoiding early pregnancy may sound like an obstacle course for inner-city kids, but it appears that that was the ticket out of the old neighborhood for more than 1,700 children born in the early 1960s who grew up to become successful adults.

Researchers at Johns Hopkins University monitored children who were born between 1960 and 1965 until they were 27 to 33 years old, and their mothers. They found that 79 percent of the children earned high school diplomas or equivalency degrees and 76 percent were financially independent. Among their shared characteristics were average or better reading skills by age 8, not repeating a grade in school and mothers who had high school diplomas at the time the child was born. The study's authors concluded that improving language and reading skills in public schools and prevention of smoking and teen pregnancy are clearly indicated as predictors of success. (*Pediatrics*, January 1997)

... DNA fingerprinting.

Some 3.7 million new mothers this year will receive information on ways to positively identify their child using DNA fingerprinting. "Guardian DNA" was developed as a child identification/safety system by Irvine, CA-based InVitro International. Child advocates say there is a need for DNA identification since other methods are unreliable. Babies are impossible to identify by traditional methods because they don't develop fingerprints until age 6 or 7, their blood profiles change during the first few years and dental records are moot.

With Guardian DNA, parents can obtain a sample of DNA with a cotton swab, attach a confidential bar code and send the sample to a secured facility where it is stored anonymously for 18 years. Only the parents, in conjunction with law enforcement officials, can access the sample. For information, call (714) 851-8356. (Business Wire)

Recommended Reading

EATING DISORDERS AND OBESITY: A COMPREHENSIVE HANDBOOK — *Kelly D. Brownell and Christopher G. Fairburn Eds., Guilford Press, 583 pages, $56.95 (hardcover)*

This is one of those handbooks that is really a handbook. With an excellent index, a succession of chapters written by on-line, in-practice and in-research luminaries in the field such as Stewart Agras, Brownell, Adam Drewnowski, Fairburn, Richard Keesey, Sarah Leibowitz, Alan Marlatt, Judith Rodin, and Terence Wilson, it is probably the best current resource for therapists dealing with these important problems.

PEDIATRIC NEUROPSYCHOLOGY IN THE MEDICAL SETTING — *Ida S. Baron, E.B. Fennell and K.K.S. Voeller, Oxford University Press, 441 pages, $55 (paperback)*

Excellent physiological coverage without sacrificing psychological functions such as attentional processes, psychosocial variables and such topics as levels of consciousness after head injury.

THE APSAC HANDBOOK ON CHILD MALTREATMENT — *J. Briere, L. Berliner, J.A. Bulkley, C. Jenny and T. Reid Eds., Sage, 447 pages, $32.95 (paperback)*

This is another truly invaluable handbook of the best available information to date on abuse, its consequences, the therapeutic modes to which various types of abuse respond, and the "art" of inquiry concerning the specific experiences an abused child has suffered.

Bibliography for risk-taking girls in children's books

D.W. Flips. Marc Brown, Little, Brown, 1987. Ages 2-5

D.W. Rides Again! Marc Brown, Little, Brown, 1993. Ages 2-5

JoJo's Flying Side Kick. Brian Pinkney, Simon & Schuster, 1995. Ages 3-7.

Mermaid Janine. Iolette Thomas, Scholastic, 1991. Ages 2-5.

On the Pampas. Maria Cristina Brusca, Holt, 1991. Ages 4-8.

Mirette on the High Wire. Emily Arnold McCully, Putnam, 1992. Ages 5-9.

Circus Dream: The Making of a Circus Artist. Kathleen Cushman and Montana Miller, Little, Brown, 1990. Ages 10-14.

Run for Your Life. Marilyn Levy, Houghton, 1996. Ages 13-14.

Sarah's Boat: A Young Girls Learns the Art of Sailing. Douglas Alvord, Tilbury House, 1994. Ages 9-12.

The True Confessions of Charlotte Doyle. Avi, Orchard, 1990. Ages 10-14.

Climb or Die. Edward Myers, Hyperion, 1994. Ages 10-13.

Taking Flight: My Story. Vicki Van Meter with Dan Gutman, Viking, 1995. Ages 10-13.

The Gadget War. Betsy Duffey, Viking, 1991. Ages 7-10.

Sable. Karen Hesse, Holt, 1994. Ages 6-10.

Hannah's Fancy Notions: A Story of Industrial New England. Pat Ross, Viking, 1988. Ages 7-9.

The Bread Winner. Arvella Whitmore, Houghton, 1990. Ages 9-11.

NEATE to the Rescue. Debbi Chocolate, Just Us Books, 1992. Ages 9-11.

Freedom Songs. Yvette Moore, Orchard, 1991. Ages 12-14

Girls and Young Women Inventing: Twenty True Stories about Inventors. Frances A. Karnes and Suzanne M. Bean, Free Spirit Press, 1995. Ages 9-14.

Girls and Young Women Leading the Way: Twenty True Stories about Leadership. Frances A. Karnes and Suzanne M. Bean, Free Spirit Press, 1993. Ages 10-14.

This bibliography is reprinted from *Great Books for Girls: More than 600 Books to Inspire Today's Girls and Tomorrow's Women* (Ballantine, 1997, $12.95, paperback) by Kathleen Odean. She is the lower school librarian at Moses Brown School in Providence, RI. Visit your local bookstore, or call the publisher at (800) 733-3000.

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Resources

Guide urges physicians to take 'media history'

The American Medical Association's "Physician Guide to Media Violence" recommends that clinicians take a "media history" to determine potential causes of behavioral and psychological problems. The 35-page guide can be obtained by writing to the American Medical Association at 515 N. State St., Chicago, IL 60610. The guide costs $3 ($2.25 for AMA members). For information, call the AMA at (312) 464-5563.

Violence prevention videos aimed at teen problems

A new 10-part video series on violence prevention, *Peace*talks, is available from the Bureau for At-Risk Youth. The series features well-known youth counselor Michael Pritchard, who talks to real kids from real schools in the videos. Each of the 10 half-hour videos offers practical strategies for dealing with anger, conflict resolution, racial conflicts, drugs, alcohol and guns, dating pressures and sexual harassment. Teachers' guides with discussion topics and follow-up activities are included. For orders and information, write to the Bureau for At-Risk Youth, P.O. Box 760, Plainview, NY 11803-0760 or call 1-800-99-YOUTH.

What's New in Research

Piano training helps wire brains for math, science

When it comes to wiring the brain for future math and science skills, a piano keyboard is better than a computer keyboard, according to a recent two-year study of preschoolers. Researchers found that children who received piano/keyboard training scored 34 percent higher on tests measuring spatial-temporal ability than other groups tested. The four research groups included children who received daily singing lessons and two private piano lessons each week; daily singing lessons only; two private computer lessons each week; or no instruction in either music or computer.

The researchers explained that musical training encourages formation of the neural pathways used for spatial-temporal reasoning. Even though children are born with the nerve cells, the pathways or connections are formed through experience and learning. While the computer is good for learning numbers and letters, it does not teach critical thinking, the researchers said. Music education teaches spatial concepts. Music is simply notes arranged in space and time.

"Music training causes long-term enhancement of preschool children's spatial-temporal reasoning," Frances Rauscher, PhD, and Gordon Shaw, PhD, *Neurological Research*, 19(1):2-8, 1997. For reprints, write to Dr. Shaw, Department of Physics, University of California, Irvine, CA 92717.

Few studies detail safety of antipsychotics for kids

A 1995 review of antipsychotic drug therapy conducted at Case Western Reserve University School of Medicine found few controlled studies examining short- or long-term safety and efficacy of the use of these agents in children and adolescents with psychosis. The author notes the "relative paucity" of studies despite the widespread use and potent action of these medications.

Psychopharmacology research has demonstrated that children's and adolescents' responses to psychotropic medications may be significantly different than those of adults. The author suggests that the pharmacokinetics and pharmacodynamics of a medicine may vary between adults and children and that apparent treatment failures or declines in efficacy may be due to developmental changes in biodisposition rather than medication tolerance.

"Antipsychotic medications in children and adolescents," Robert L. Findling, MD, et al., *Journal of Clinical Psychiatry*, 57(9):19-23, 1996. For reprints, write to Dr. Findling, Department of Psychiatry, 11100 Euclid Ave., Cleveland, OH 44106-5080.

IVF or GIFT twins more likely to have low birth weight

A recent study of twins conceived by *in vitro fertilization* (IVF) or *gamete intrafallopian transfer* (GIFT) shows that they are more likely to have low birth weight, or have differing birth weights from each other, according to an article in last month's issue of *Obstetrics and Gynecology*. Researchers studied 384 sets of twins delivered between 1990 and 1995. Of these deliveries, 279 were spontaneously conceived and 105 sets of twins were conceived through IVF or GIFT. The study found that IVF and GIFT twins were likely to have a 20 percent difference in birth weight from each other or have a low birth weight (less than 5.5 pounds). Researchers theorize that the disparity in birth weight may be because IVF and GIFT twins are more likely to be fraternal twins with different genes, compared to spontaneously conceived twins, who are more likely to be identical.

"Twin pregnancies conceived by assisted reproductive techniques: maternal and neonatal outcomes," James Bernasko, MD, et al., *Obstetrics and Gynecology*, 89(3):368-372, 1997. For reprints, contact Dr. Bernasko, Department of Obstetrics, Gynecology and Reproductive Sciences, Mount Sinai School of Medicine, 1 Gustave C. Levy Place, New York, NY 10029.

Girls' fiction

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physically active, a healthier way for girls to view their bodies than the more common emphasis on beauty and thinness.

Two popular books about an aardvark named D.W. illustrate the principle of persistence. In *D.W. Flips*, D.W. initially scoffs at learning anything as easy as a forward roll in her gymnastics class. But it takes a week of constant practice to master the roll, and her pride when she does so is clear. In *D.W. Rides Again!*, D.W. once more dedicates herself to practicing, this time in order to be free of the training wheels on her bicycle. Again we see her hard at work every day until she succeeds.

Three other books for young children show girls reaching their athletic goals through hard work and courage. In *Mermaid Janine*, African-American Janine makes her swimming lessons more effective through practicing, strengthening her legs by jumping rope, and even eating vegetables she dislikes. The young girl in *JoJo's Flying Side Kick*, also an African-American, overcomes her nervousness and breaks a board with a kick to earn her yellow belt in tae kwon do. *On the Pampas*, set on a ranch in Argentina, depicts two girls who improve their riding skills, and learn through trial and error to lasso cattle.

Circus performance is a particularly challenging area of athletics. In the beautiful picture book *Mirette on the High Wire*, a Parisian girl becomes a tightrope walker. Taught by a famous tightrope artist, Mirette gets up two hours early to practice every day, falling many times as she slowly gains balance and confidence. A nonfiction book for older readers, *Circus Dream: The Making of a Circus Artist*, follows an 18-year-old American girl as she studies to be a trapeze artist in France. Photographs and diary entries convey the physical and psychological challenges she faces every day.

For a bibliography of books in this article, see this month's insert.

The adolescent girls in *Run for Your Life* also face physical and psychological challenges every day in their Oakland housing project. Based on a true story, this outstanding novel focuses on girls who join a community center girls' track team, a team that changes their lives.

Organizational abilities come to the fore in political arenas as well as business. Two novels about African-American girls show them learning skills that help promote a cause.

The art of sailing combines physical skills and mechanical knowledge. In *Sarah's Boat*, a heavily illustrated book for older children, 12-year-old Sarah feels accomplished and independent when she sails a small boat on her own and defeats some overconfident boys in a race. In a different time, prim and proper Charlotte becomes involved in an 1832 mutiny in *The True Confessions of Charlotte Doyle*. By the end, she can climb the rigging as well as a sailor can, and refuses to return to her sedate life.

Mountain-climbing also presents difficulties to be solved with strength and mechanical dexterity. In *Climb or Die*, a girl and her brother must climb a mountain to save their stranded parents. Danielle leads the way with her wilderness skills, but also improvises needed tools.

In a true adventure, *Taking Flight*, sixth-grader Vicki Van Meter describes how she flew a small plane across the Atlantic in 1994, relying on her math skills and careful preparation. Her account emphasizes the pleasures of setting goals and reaching them.

Mechanical skills are at the heart of a novel for younger readers, *The Gadget War*, about a third-grade girl who loves inventing. She likes to use tools to create new devices, and she makes it look like fun. In *Sable*, another short novel for younger readers, a girl earns her family's permission to have a dog by building a fence by herself — a task she conquers with difficulty.

Women own one-fourth of small businesses today, yet fictional girls rarely show any interest in earning money. However, two historical novels focus on girls who turn traditional female tasks into money-making ventures. In *Hannah's Fancy Notions*, a novel for young readers, a girl starts a small business making bandboxes in 19th-century Massachusetts. In a story for slightly older readers, *The Bread Winner*, 12-year-old Sarah helps her family survive the Depression by opening a bakery.

Organizational abilities come to the fore in political arenas as well as business. Two novels about African-American girls show them learning skills that help promote a cause. In *NEATE to the Rescue*, Naimah and her friends help her mother get re-elected to city council. *Freedom Songs* concerns a teenager who raises money for civil-rights workers by organizing a successful neighbor-

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hood concert.

In nonfiction, two excellent books offer essays by girls and young women who have set goals and reached them as inventors and as leaders on issues such as pollution, civil rights and poverty. *Girls and Young Women Inventing* and *Girls and Young Women Leading the Way*, like the other books described, may well inspire readers to expand their own horizons and try something new in non-traditional fields. ■

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*For a bibliography of books in this article, see this month's free insert.

Kathleen Odean is the author of the new book *Great Books for Girls: More than 600 Books to Inspire Today's Girls and Tomorrow's Women* (Ballantine). She is the lower school librarian at Moses Brown School in Providence, RI.

Mary Pipher

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Other. Drawing on her grandparents' experience as farmers in Colorado in the '20s and '30s, Pipher says that in that era, families understood who their enemies were: blizzards, the Depression and locusts. All things external to the family.

Pipher says we've been slow to catch on to our enemies in the '90s "because things look the same." Loss of community tops her list of enemies and can be understood in the simplest examples of people retreating to their appliances. There was a time, she explains, that blistering heat would drive people outdoors together to the shade of trees. Today people retreat to their air-conditioned houses. Even cattle auctions, traditional social events of the year in some circles, are now held by satellite, says Pipher. She believes youth gangs are reflections of our lost communities. "Kids need community," she emphasizes.

Pipher's enemy list includes the "tool pile" on which our lives are built: faxes, computers, car phones and television sets. "Our children are being raised by appliances," she says. The danger to kids is how they learn about sexuality, relationships, manners and other issues. On television, they learn to have relationships with fictional, cardboard characters, not real people, says Pipher. In addition, sitcoms are teaching our kids bad manners. In the last decade, she notes that kids insult each other more and are ruder to one another and to adults.

Finally, Pipher describes the danger to our families in putting too much value on consumption. (In her grandmother's day "consumption" referred to tuberculosis, she observes.) Today's consumption manifests itself in the suffocating messages of television advertising. Our children learn to believe that they are entitled to immediate gratification, that pain is unnatural and that everything is fixable, she says.

Pipher's best "short advice" to parents of the '90s is to be the antidote to all the advertising and television programming. She recommends starting with family meals, family vacations and simply spending more time outdoors — together. ■

Family tales hold great value

Family stories do more than entertain. Historically, they are ways of defining identity by codifying values and preserving traditions. Children's librarians Anne-Marie Forer, MLS, and Nancy Schwegler, MLS, at Bradley Hospital, which treats children with psychiatric and developmental disorders, in East Providence, RI, suggest the following resources about family stories:

Annie Stories: A Special Kind of Storytelling by Doris Brett. New York: Workman Publishing, 1986.

Telling Your Own Stories by Donald Davis. Little Rock: August House, 1993.

Did I Ever Tell You About When Your Grandparents Were Young? by Deborah and Greg Lewis. Grand Rapids: Zondervan Publishing, 1994.

Did I Ever Tell You About When Your Parents Were Children? by Deborah and Greg Lewis. Grand Rapids: Zondervan Publishing, 1994.

The Family Storytelling Handbook by Anne Pellowski. New York, Macmillan, 1987.

Black Sheep and Kissing Cousins: How Our Family Stories Shape Us by Elizabeth Stone. New York: Times Books, 1988.

For more information, contact the Emma Pendleton Bradley children's library office at (401) 434-3400, ext. 231.

Commentary

Let's take a closer look at our differences

I've just returned from a two-week visit to Japan. My principal purpose was to look into the ways in which the Japanese "sleep their babies," and to explore other aspects of child-rearing practices that may relate to crib death.

The Japanese have one of the lowest rates of crib death, or sudden infant death syndrome (SIDS), in the world. One has to wonder why. We need to know how they do it. Among developed countries, the United States has one of the highest rates of SIDS, which usually occurs between two and five months of age.

In Japan I lectured at universities and hospitals, and at meetings where SIDS parents mingled with concerned professionals to discuss the current state of knowledge about crib death. With each successive contact and at all of the sites, I became further convinced that as low as their crib death rate is, the Japanese intend to reduce the rate to zero. I also found that the Japanese are as saddened by a stillbirth or an unintended, spontaneous abortion of a wanted child as by the death of a baby three months old.

> *We have a lot to learn from countries such as Japan and Sweden, where the homicide rates are much lower than those in the U.S., and where the care of children, and even the attitudes toward conception, are so very different.*

In the U.S., about two crib deaths occur in 1,000 births. These are due to still-unexplained causes, although we know that certain conditions are associated with increased vulnerability. Risk factors include poverty, sleeping in the stomach-down position and having parents who smoke.

Shortly after returning from Japan, I attended the meetings of the Society for Research in Child Development, and learned that the U.S. ranks among the highest among developed countries in *homicide* rate. Japan has the lowest rate. This was of more than passing interest as I noted the parallel with crib death rates. This is not to imply that crib deaths are homicides (they rarely are), but rather that both crib death and homicide occur in social contexts. Japanese babies sleep for at least the first year of their lives, and usually much longer, in the bedroom of their parents — and indeed on or around the tatami-bed of their parents. The baby's voice is never far from the ears of the parents. Proximity of parent and child in the first year of life is definitely related to low crib death rates; babies who sleep in the same room as their parents rarely die of crib death.

Japanese babies who are breast-fed are often fed for long periods of time. This is a touchy area of discourse. When I tell Americans that Japanese "babies" are sometimes breastfed for as long as three to five years, they respond with incredulity. Americans seem to believe that such an "attachment" of mother and child approaches psychopathology. But the Japanese have a very low homicide rate, and it is safe to walk the streets of Tokyo, the most densely populated city in the world! One seldom hears a car horn, nobody seems to be shouting, everyone thanks others for the slightest accommodation and there is no tipping, as everyone is simply expected to do his or her job excellently.

We must look more closely at the differences among cultures, and across nations, in the ways in which children are cared for. We have a lot to learn from countries such as Japan and Sweden, where the homicide rates are much lower than those in the U.S., and where the care of children, and even the attitudes toward conception, are so very different.

President Clinton has assembled a White House Conference on the development of the human brain and behavior, to occur April 17, virtually as we go to press. We will report the results of this conference, and will devote more space to cross-cultural and international differences in child-rearing perspectives. ■

Lewis P. Lipsitt

Dr. Lipsitt is editor of *The Brown University Child and Adolescent Behavior Letter*.

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Cognitive Development

Children who think differently may behave differently

By Myrna B. Shure, PhD

When I was a nursery school teacher, I noticed how children differed in their strategies when they wanted but were refused a toy another child had. Some would hit the other child or grab the toy. Others would tell the teacher, and still others would walk away, pout and give up.

When Zachary, age 4, was predictably refused the wagon that Peter had, he did something different. Zachary asked Peter, "Why can't I have it?"

"Because I *need* it," replied Peter. "I'm pulling the rocks."

"I can help you pull the rocks," answered Zachary. "We can pull them together."

"OK," answered Peter enthusiastically. Then they both went off with the wagon, pleased with their own solution to the problem.

Children who are given the skills and the freedom to resolve their own problems and think for themselves take greater responsibility for their behavior.

I thought that was rather sophisticated thinking on Zachary's part. He was able to mesh his needs with those of Peter's, a skill that helped him find success. Was that unusual for a 4-year-old? As I began watching children more systematically, I realized there were a number of different strategies to obtain a toy from another child that more socially competent preschoolers used, such as, "You'll have more fun if you play with me," or "I'll show you how to play with it."

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Inside This Issue

Many children with chronic tics can be treated successfully with stimulant medication.
See page 4

American girls are showing signs of puberty at younger ages than suggested in previous studies.
See page 4

Guest Commentary: A mother writes of dealing with a child who is different.
See page 8

Coming next month:
Cognitive characteristics of adolescent suicide attempters, and implications for treatment.

This month's client handout
Teaching children *how* to think, not *what* to think.

Prenatal Development

Cocaine exposure and child outcome: What do we really know?

By Beata Napiorkowski and Barry M. Lester, PhD

Cocaine use by pregnant women and the drug's subsequent effects on the baby has been a topic of major concern in the past 10 years. The issue gained much publicity in the media in the mid-1980s, with horrifying stories of "crack babies," tremoring and writhing in nurseries around the country.

These children were written off as unfortunate victims of the war on drugs that plagued and continues to plague American society. This bleak picture was followed by studies from the scientific community, which suggested that the effects of the drug were more subtle, that the cocaine-exposed newborn lying side by side with other newborns in well-baby nurseries may not be distinguishable to the lay observer.

Studies attempted to measure these differences in an attempt to elucidate the effects of cocaine on the developing fetus. Results were often varied, sometimes contradictory.

A review of the recent scientific literature shows that we are gaining a better understanding of cocaine's

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The Brown University Child and Adolescent Behavior Letter

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Recommended Reading

RAISING A THINKING CHILD: WORKBOOK — *Myrna B. Shure, with T.F. Digeronimo, Henry Holt (an Owl Book), 192 pages, $14.95 plus $4 shipping and handling (paperback); $22.50 plus $5 shipping and handling (hardcover). Distributed by Publishers Book and Audio, (800) 288-2131.*

This workbook is based on a very successful earlier book, *Raising A Thinking Child*, which teaches how to use Shure's I-Can-Problem-Solve program, which has won four national awards. The workbook invites children as young as 4 and their parents to play the games, draw and color. In the context of having fun, the children learn to think about problems, how they and others feel, the consequences of their actions and alternatives they have in dilemma situations. The workbook seeks to teach children how to think, not what to think. It does not require the original book to be used.

MOTHERS, BABIES, AND COCAINE: THE ROLE OF TOXINS IN DEVELOPMENT — *Michael Lewis and Margaret Bendersky, Lawrence Erlbaum Associates, 408 pages, $79.95 (hardcover), $32.50 (softcover) plus shipping and handling, (800) 926-6579*

Substance abuse during pregnancy has skyrocketed, due largely to the availability of crack cocaine. The burdens on health care and educational systems are enormous, due to adverse effects on the fetus. But is prenatal cocaine exposure a convenient excuse for the adverse outcomes associated with a myriad of physical and social ills of the drug-using population? Presented here are recent scientific facts about prenatal exposure. Chapters by prominent researchers deal with what we do and do not know about the mechanisms of action of cocaine on the developing brain; strategies for studying this complex issue; implications of drug exposure and a drug-using environment for long-term cognitive, social and emotional functioning; and intervention strategies to prevent problems in developing children who are at risk.

EARLY CHILD CARE: INFANTS AND NATIONS AT RISK — *Peter Cook, News Weekly Books (Australia), 213 pages, $19.95 plus postage and handling, (03) 9326-5757.*

The author is a psychiatrist with an international reputation and a strong interest in mother-infant relationships and the conditions of the world, and in families and societies that may harm children. He is convinced from his observations of child care in many settings and in different societies that child care "by unrelated women having no lasting commitment to the child is without successful precedent in the history of our species." Much research runs counter to Cook's take on the situation, including recently disclosed results of a national study of child care conducted by the U.S. government's National Institute of Child Health and Human Development. Cook does make the important points that sometimes the most needy infants (children of the poorest families) are not included in those studies, and often the specific psychological consequences of outside-of-home child care are not studied closely enough.

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Keep Your Eye On

… reading Rx.

Pediatricians will be handing out a new kind of prescription in coming months — books — hoping that even in small dosages the time spent reading to infants and toddlers will literally help their brains grow. It's part of a new "Reach Out and Read" program founded by Barry Zuckerman, MD, at Boston Medical Center, in which pediatricians and hospitals have teamed up with book publishers to prescribe reading as part of standard pediatric care. The latest brain research suggests that reading to young children enhances their social and emotional development and is the foundation for building vocabulary skills and later educational success. Research also shows that the pediatrician is the most influential person in getting parents to follow those instructions — especially when the book is given to the child at the end of an office visit instead of, say, a sticker or a lollipop. Other pediatric practices and hospitals, such as Rhode Island Hospital, are trying similar programs (see *CABL*, December 1996). (Associated Press)

… healthier Native Americans.

Maternal and infant mortality among Native Americans have declined over the last 30 years, according to a report at the recent annual meeting of the American College of Obstetricians and Gynecologists (ACOG). But the news isn't all good, according to Alan Waxman, MD, MPH, who said significant health problems such as diabetes, cancer, alcohol abuse and heart disease remain for Native American women. "Morbidity and mortality for Native American women have shifted over the past several decades from infectious disease to diseases related to poverty and lifestyle. A diet high in calories and fat and little or no exercise are major contributors to the increase in heart disease and diabetes," said Waxman in an ACOG release.

… dollars for scholars.

The William T. Grant Foundation, which makes awards to faculty scholars who contribute to the understanding of child and youth development, is seeking applicants for its Faculty Scholars Program. Awards are for five years, totaling $250,000, including indirect costs. Institutions or individuals may obtain a brochure outlining the application procedure by writing the Faculty Scholars Program, William T. Grant Foundation, 515 Madison Ave., New York, NY 10022-5403. The deadline for applications for the 1998 award is July 1.

… call for papers.

The Society for Research on Adolescence is seeking submissions for papers to be presented at its biennial conference scheduled for Feb. 26 to March 1, 1998 at the Hotel del Coronado in San Diego. The deadline for submission is July 15. Information regarding the meeting and abstract submission procedure can be obtained from Darwin Eakins and Belinda Conrad, EC Enterprises Inc., PO Box 1793, 835 Louisiana St., Lawrence, KS 66044-8793; phone (913) 832-0737; fax (913) 832-2843.

… radiation fallout.

Disturbing but conflicting data continue to emerge in the decade since the 1986 accident at Ukraine's Chernobyl nuclear power plant. In a recent letter to the *British Medical Journal*, Joseph Mangano of the Radiation and Public Health Project in New York said he found "the leukemia rate among children aged under 1 year born in 1986-1987 (62 cases) was 30 percent higher than among other children born during the decade." He said his findings support a Greek study that found extra cases of childhood leukemia and urged more precise study of the effects of the accident. Other studies in countries closest to the site of the accident — Belarus, Finland and Sweden — have reported no rise in the incidence of childhood leukemia but have found a clear rise in the incidence of thyroid cancer in children. (Reuters)

… power tea.

Eunice Kennedy Shriver's work in helping young people avoid destructive behavior by strengthening their skills to make positive and life-enhancing decisions was honored recently at the second annual Women's Power Tea attended by more than 200 women in business, public service, education, health and communications. Tipper Gore, an honorary tea chair, presented the Lavinia Engle Tribute to Shriver at the event.

… full benefits for kids.

A new school program for 1,300 low-income Denver-area school children will enable them to receive full health benefits for $3 a month as part of a program called School Connections sponsored by the health maintenance organization Kaiser Permanente. The plan is part of a two-year collaborative pilot program in three Colorado school districts (Adams County, Denver and Sheridan) that have school-based student health centers. Under the program, students receive services at the school health centers and also become full Kaiser members eligible to receive complete inpatient and outpatient services for a $5 co-payment. Prescriptions are free. The program is expected to cost Kaiser $1 million annually. (*School Board News*)

What's New in Research

Expert says group data support stimulant use for tics

One of the thorniest issues for clinical management of children with attention-deficit hyperactivity disorder (ADHD) is the potential for young patients to develop tics after administration of a course of stimulants to control attentional problems.

Within the medical community, it is a subject that is frequently debated because methylphenidate HCl (Ritalin) is contraindicated in physician desk references on drug information for patients with tics or family histories of tic disorders. Still, there are a number of ongoing studies showing that "many children with ADHD and chronic tics can be treated successfully with stimulant medication," according to Kenneth D. Gadow, PhD, at the department of psychiatry and behavioral science at the State University of New York at Stony Brook. The ambiguity lies in the high comorbidity of ADHD and Tourette's syndrome and the unpredictable nature of tic disorders.

Gadow, author of numerous articles on the subject, discussed the topic recently with *Psychopharmacology Update*, a sister publication of *CABL*, noting the dilemmas confronting clinicians in the management of ADHD:

- Attentional problems frequently occur in children with Tourette's syndrome.
- The waxing and waning of tics make it difficult to study and to directly attribute cause and effect.

Some children with no previous history develop tics when treated for ADHD with stimulants, although discontinuation of the medication usually makes these transient movements disappear.

In cases of comorbid ADHD and tic disorder, "There is no evidence on the basis of group data that stimulants exacerbate tics," said Gadow in a telephone interview. However, there do appear to be some children who show an individual sensitivity and whose tics worsen when stimulants are introduced into treatment, he said. Given the natural tendency for tics to fluctuate in severity, it is difficult for a doctor to determine at the onset of tic worsening whether the medicine caused the tics. Unless the tic exacerbation is debilitating to the child, Gadow said that some experts advise close monitoring over several days to see if the tics will subside.

A study Gadow and his colleagues reported in the *Archives of General Psychiatry* in 1995 found that children with ADHD and comorbid tic disorder could be effectively treated with Ritalin. However, the study warns that the findings "should not be interpreted as indicating that methylphenidate is universally benign with regard to tic exacerbation." The authors also note that all drugs are capable of inducing or exacerbating comorbid conditions.

Gadow, whose work is supported by a grant from the National Institute of Mental Health, said that preliminary data based on the first two years of follow-up studies on the long-term use of Ritalin in children with ADHD and tic disorders suggest that they can be successfully maintained on their medication without worsening the tic disorders. The prospective study

Girls are reaching puberty at younger ages than before

Pediatricians are reporting that American girls are showing signs of puberty at younger ages than suggested in standard textbooks or previous studies, according to a recent study by a practice-based research network of the American Academy of Pediatrics. The findings are significant because physicians use age guidelines to detect growth and development problems and to provide appropriate guidance and patient education. Specifically, the study found that secondary sexual characteristics (pubic hair and/or breast development) are found in 14.7 percent of white girls and in 43.8 percent of African-American girls between their 8th and 9th birthdays. The cross-sectional study found that on average, African-American girls begin puberty between 8 and 9 years of age, and white girls by 10 years of age. The study conducted by 225 pediatricians who belong to Pediatric Research in Office Settings (PROS) analyzed data for more than 17,000 girls between the ages of 3 and 12. The authors concluded that "earlier puberty is a real phenomenon, and this has important clinical, educational and social implications." The authors suggest that the timing and content of sex education programs may need revision and that further investigation of a possible relationship to breast cancer prevalence requires further study. The authors also note that additional study may be warranted on the psychological consequences of immature children whose bodies are maturing at an earlier age.

"Secondary sexual characteristics and menses in young girls seen in office practice: a study from the pediatric research in office settings network," Marcia E. Herman-Giddens, PA, et al., *Pediatrics*, 99(4):505-512, 1997. For reprints, write to Ms. Herman-Giddens, Office of the Chief Medical Examiner, CB#7580, University of North Carolina, Chapel Hill, NC 27599-7580.

Teach your child how, not what, to think: A cognitive approach to behavior

by Myrna B. Shure, Ph.D.

We have many ways of changing the poor behavior of young children. We can tell them what to do and what not to do. We can explain why our idea is a good one. We can model, coach or ignore and hope that what they do will go away. But these approaches are essentially the same — we are doing the thinking for children.

"Interpersonal Cognitive Problem Solving" (ICPS) is different. We introduce problem-solving techniques to children. We do not teach children what to think or do, but *how* to think so they can resolve problems successfully with peers and authority figures. Also known as "I Can Problem Solve," the program teaches children about how they and other children feel and offers options for reaching their goals.

We have learned that as early as age four, children who can think about their own and others' feelings, consequences of actions, and alternative ways to solve problems show fewer behavior problems than youngsters who don't think but merely react to the immediate moment. Two decades of research indicate that ICPS-competent children of various ages and IQ levels have significant advantages. These children are:

- ✓ less easily frustrated;
- ✓ less likely to lose their tempers;
- ✓ less impatient;
- ✓ less socially withdrawn;
- ✓ more caring about others;
- ✓ more likely to share and take turns; and
- ✓ better able to make friends than other children.

For preschoolers, lesson-based games teach early language concepts that can set the stage for later problem solving. The words SAME and DIFFERENT can help children recognize that hitting and kicking are the same because they can both hurt someone, and then help them think of something different to do. Children then learn that different people feel differently about the same thing, that feelings change and that we learn about feelings by watching, listening and asking.

After learning other problem-solving concepts, children are ready for games and dialogues that teach solutions and consequential thinking skills, using their own and others' feelings. They learn that if one solution doesn't work, or is not a good idea, it is possible to try a different way. Most importantly, teachers and parents are taught ICPS "dialoguing," a problem-solving communication style.

What you can do

For example, Cheryl's teacher talked to her this way:

Teacher: What happened? What's the matter?

Cheryl: It's mine!

Teacher: What happened when you grabbed the clay?

Cheryl: She hit me.

Teacher: How do you think Vicki feels when you grab from her?

Cheryl: Mad, but I don't care. It's mine!

Teacher: How did you feel when Vicki hit you?

Cheryl: Mad.

Teacher: Grabbing is one thing you can do. Can you think of something different you can do so she won't hit you, and you both won't be mad?

C (to V): Can I have the clay?

Vicki: NO!

Teacher: You'll have to think of a *different*, new idea.

Continued on next page . . .

... Continued from previous page

C (to V): If you let me have the clay, I'll build you a castle. Do you like that?

Happy with their own solution, the children felt proud and the teacher didn't have to explain why children should share. However, this should not be taken to mean that children always should end up with what they want. Good problem solvers can cope better with disappointment, too.

One ICPS teacher told Johnny why he couldn't have Play-Doh at an inconvenient time and asked, "Can you think of something different to do now while you wait?" This child thought for a moment, then shouted happily, "I'll go paint." If the teacher had simply said, "I can't help you now, why don't you go paint?" the child probably would have whined, "I don't want to paint, I want the Play-Doh."

In addition to negotiating for what they want, children also should learn to cope with the frustration of not always getting what they want. One mother, who used to yell at her child for interrupting her on the phone, tried asking, "Can I talk to you and to my friend at the same time?" And her child, whose previous reaction was to throw a tantrum, said, "No, and I can think of something different to do."

Our research has shown that parents can teach ICPS skills to their young children, and that impulsive children become less impatient, less over-emotional, and less aggressive. Withdrawn children learn to express their feelings and stand up for their rights. ■

Dr. Shure is the author of "I Can Problem Solve: An Interpersonal Cognitive Problem Solving Program" (to order, call Research Press at (800) 519-2707) and *Raising a Thinking Child: Help Your Young Child Learn to Resolve Everyday Conflicts and Get Along with Others,* New York: Henry Holt, 1994 (to order, call (800) 288-2131).

Let your child do the thinking

Here are two examples of how parents often prevent their children from thinking for themselves, by doing the thinking for them.

Scenario 1

Tracy: Mommy, he hit me!

Mother: Hit him back.

Child: But I'm afraid.

Mother: If you don't hit him back, kids will keep on hitting you.

Child: OK.

Scenario 2

Kelly: Mommy, he hit me!

Mother: The next time he does that, tell the teacher.

Child: But he'll call me a tattletale.

Mother: If you don't tell the teacher, kids will keep on hitting you.

Child: OK.

Different advice, but the same ineffective approach. In the first scenario, the child no longer has to think about what to do, since his mother has decided for him. In the second case, the child arranges to have the problem handled for him, by the teacher.

The Brown University Child and Adolescent Behavior Letter

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involves 34 children, mostly boys, who are being maintained on optimal doses of stimulant medication and observed in simulated classroom situations every six months, he said.

The bottom line, according to Gadow, is that the effects of Ritalin, which has been used in the treatment of ADHD since the 1950s, are well-known and documented and ongoing. A double-blind, placebo-controlled study on the effects of withdrawal of medication on 20 children will be completed by the end of the summer, he added. ■

For further information and for reprints, write to Dr. Gadow, Department of Psychiatry and Behavioral Science, Putnam Hall, South Campus, SUNY at Stony Brook, Stony Brook, NY 11794-8790.

U. of Wisconsin offers help on child medications

The University of Wisconsin Child Psychopharmacology Information Service, a self-supporting service of the university's department of psychiatry, provides database searches for parents and professionals on child psychopharmacology. In the first-quarter newsletter *Just The FAX* in 1995, the editor reported that there is not enough data to confirm or refute the hypothesis that use of stimulants either causes or unmasks latent Tourette's syndrome. "However, if symptoms persist, stimulants may be helpful," the newsletter states. It warns clinicians to use caution and monitor the impact on tic symptoms. The newsletter notes that pemoline (Cylert) is far more likely than other stimulants to aggravate a tic disorder.

The Child Psychopharmacology Information Service recently revised its patient medication guide on attention-deficit hyperactivity disorder. The medication guide also includes information on non-stimulant drugs. Copies cost $4.50 and may be obtained by writing the Dean Foundation, 2711 Allen Blvd., Middleton, WI 53562, or calling (608) 827-2390. Make checks payable to the Dean Foundation. Discounts are available for 10 copies or more.

Children's behavior

from page 1

I also watched how teachers, and later how parents and other caregivers, talked to children when they did hit another child or grab a toy. Over the years, I have divided the way we talk to kids into four levels.

Four levels of communication

The first level, called *power assertion*, includes statements like "If you two can't share the toy, I'll put it away so neither of you can have it." Other examples include "Go to time out!" or "How many times do I have to teach you to share your toys?"

While all of us resort to power assertion when we feel exasperated, too much of this kind of talk can make children feel angry, frustrated and powerless. Do children who comply do so merely out of fear of punishment? Or, will they in time even become immune to being yelled at or otherwise punished in these ways? Is a child who says "I don't care," when others hit him or grab a toy back, a case in point? If a child at age 4 does not care what happens to him now, will he develop empathy to care what happens to others later?

The second level is *positive alternatives*. Instead of focusing on what not to do, focus on what *to* do. Examples include, "Ask him for the toy," or "Share your toys."

Level three, *induction*, adds explanations and reasons; for example, "If you hit him, you might hurt him," "If you grab toys, you won't have any friends," or "I feel angry when you grab toys."

I have tried all of these techniques, and none of them worked. Then it occurred to me that maybe, by age 4, many children have already heard these suggestions and explanations a thousand times, and simply tune out. We then complain, "My child never listens to me!" We are telling them what they already know. We are doing the thinking for the child.

How can even very young children become good problem-solvers? How can we help children become thinking, feeling human beings who won't want to hurt themselves or others, and who will be able to make good decisions now and later in life?

The problem-solving level

We can climb to level four, or what I call the top rung of a ladder of talk — the problem-solving rung. Instead of demanding, suggesting or even explaining to children what they should and should not do, and why, perhaps we could guide behavior a new way: by helping children learn to *think* about the problem, and to tell us what and what not to do, and why. Instead of demanding, suggesting or even explaining — all one-way monologues — we can engage children in a dialogue. We can ask questions such as:

- What's the problem? What happened?

(Continued on page 6)

- What happened when you (hit him/her? grabbed the toy?)
- How did he/she feel when you (hit him/her? grabbed the toy?)
- How did *you* feel when he/she hit you?

Can you think of something *different* to do so you both won't feel that way and he/she won't hit you?

After a while, you can shorten the dialogue. If a brother is teasing his sister, you can simply ask, "Can you think of a different way to tell your sister how you feel?" That may be all that needs to be said.

A means of empowering

Questions such as these empower children to think of solutions, potential consequences of their behavior, and how both they and others feel.

These techniques can be used in problem situations that arise between children and adults, too. For example, instead of saying, "I feel angry when you jump on the couch," you can ask, "How do you think I feel when you jump on the couch?" And then, "Can you think of a *different* place to jump?"

Our research of 25 years shows that children who are given the skills and the freedom to resolve their own problems and think for themselves take greater responsibility for their behavior, are less likely to want to hurt themselves or others, are less likely to fly off the handle when things don't go their way, are less aggressive and are less socially withdrawn. They do not feel frustrated or angry. They feel proud. ■

Myrna B. Shure is a professor of clinical and health psychology at Allegheny University (formerly Hahnemann University) in Philadelphia. She is the author of *I Can Problem Solve: An Interpersonal Cognitive Problem Solving Program* for schools (Research Press, Champaign, IL, 1992) and *Raising a Thinking Child* for parents, now in paperback (Pocket Books, 1996; audio, BDD Audio, 1996). Her recent *Raising a Thinking Child Workbook* (Holt, 1996) is recognized as a model juvenile-delinquency prevention program by the Strengthening America's Families Project at the University of Utah and the federal Office of Juvenile Justice and Delinquency Prevention. Contact Dr. Shure at Allegheny University, Broad and Vine, MS 626, Philadelphia, PA 19102; (215) 762-7205.

Cocaine

from page 1

pharmacological action and a clearer picture of the behavior of newborns of cocaine-using mothers. We are now able to describe the pathway that cocaine takes when it is ingested by the mother, including specific neuronal receptors and biochemical pathways. However, extrapolating behavioral and developmental effects has continued to pose a challenge.

Literature is sparse

First, there are very few follow-up studies that have looked at cocaine-exposed infants beyond the infancy period, and even fewer that have studied children older than 2 years. Of those handful of published studies, one by B. Hurt and his colleagues found no differences between cocaine-exposed and non-exposed children in abnormal tone or reflexes at 6 and 12 months of age on the Bayley Scales of Infant Development, as well as no differences in scores on the Mental Development Index and Psychomotor Development Index at 30 months.

In studies by D. Chasnoff of three-year outcome of cocaine-exposed children, no differences in mean IQ were observed between exposed and controls, although cocaine exposure predicted poor verbal reasoning at age 3. These researchers concluded that generalizations about the fate of drug-exposed children must await additional research into the outcome of the broader population of drug-exposed children, including examining the roles of maternal and environmental factors across a variety of socioeconomic levels.

Another study, by C. Nullman, found that cocaine-exposed children had significantly lower scores than control subjects for both verbal comprehension and expressive language on the Reynall language test, independent of postnatal home and environmental confounds. However, this study also concluded that it is impossible to attribute the measured effects to cocaine alone, as women who use cocaine during pregnancy, seemingly invariably, smoke cigarettes, drink alcohol and use other drugs.

Indeed, this fact poses the second challenge to formulating conclusions about cocaine's effects on child development. The problem is one of polydrug use, and studies have not been able to isolate the effects of cocaine from the effects of other drugs.

In addition, children exposed to cocaine often grow up in environments that include poverty, violence, high stress and chaotic lifestyles that could adversely affect development outcome independent of cocaine. Studies have not been able to separate environmental effects from pharmacological effects on the developmental outcome of the child. Cocaine, in fact, becomes a marker variable for polydrug use and a compromised lifestyle, and until large, multisite, prospective studies are conducted to study the coincidence of these factors, we will not be able to untangle cocaine's specific effects.

Self-reports may be unreliable

Another problem is that research studies often rely on mothers' self-reports of drug use or urine toxicology screens as evidence of drug use. In the former case, unreliable underreporting of drug use is a documented problem, while in the latter, the inability to determine use prior to the immediate time period detectable by urine screen confounds data collected. Newer methods for maternal drug detection have included testing of the meconium (the newborn's first stool), which provides information about the mother's drug use throughout the second and third trimesters of pregnancy.

A third issue involves the limitation of current exams and scales used to test the developmental progress of the drug-exposed infant and child. Since these tests were developed to evaluate the progress of normal, healthy children, they may not be sensitive enough to evaluate the seemingly subtle effects of drug exposure.

For example, in a study that we conducted, we used the Newborn Intensive Care Unit Network Neurobehavioral Scale, developed at Brown University, specifically designed for prenatally drug-exposed infants to look at differences in the newborn period. The immediate postnatal period is of specific interest as it represents drug effects on the child before the influence of other environmental factors. We found that cocaine-exposed newborns showed increased tone and motor activity; more jerky movements, startles, tremors and back arching; and more signs of central nervous system and visual stress than did unexposed infants.

The cocaine-exposed newborns also showed poorer visual and auditory following of objects presented by the examiner. Newborn assessment tools frequently employed to study the normal infant may not have been sensitive enough to pick up these differences. Perhaps with the development of more sensitive tests for the drug-exposed infant beyond the newborn period, clearer behavior and/or developmental effects of drug use will be seen, if indeed there are such effects to be seen.

Current study of in utero fetus

We currently have work in progress that is attempting to go "backward" in time by evaluating fetal behaviors in utero of drug-exposed infants compared to non-exposed infants. Using real-time ultrasonography, fetal heart rate monitoring and measures of cerebral blood flow, we are documenting fetal movements and behaviors, including reactions to various sounds and vibrations.

> *We believe strongly that it is scientifically premature to presume that cocaine's effects seen in the newborn period do or do not affect later development.*

In a preliminary study, we found that drug-exposed fetuses show a dampening of the normal increase in heart rate to a vibroacoustic stimulus. Our aim is to develop an assessment scale for the fetus comparable to that for the newborn and sensitive to the behaviors of drug-exposed fetuses. We will study longitudinally the development of drug-exposed fetuses through early childhood and on to school to understand the developmental processes that may be affected by prenatal drug exposure.

It is interesting how in 10 years the pendulum has swung from the view of cocaine as a devastating drug that causes brain-damaged children to the argument by some that exposure to cocaine in the womb has virtually no effect on early childhood development.

The postnatal environment is now spoken of as most responsible for the development of the drug-exposed child. Our knowledge base at this time, however, does not permit drawing any definitive conclusions because:

- Few longitudinal studies have been conducted and their results are inconsistent.
- Effects of cocaine are confounded with the effects of other drugs and with environmental factors.
- Methods of drug detection are not accurate.
- Neurobehavioral tests that have been used may not be appropriate to study drug effects.

In light of these issues, we believe strongly that it is scientifically premature to presume that cocaine's effects seen in the newborn period do or do not affect later development. It has taken 10 years of research to understand the magnitude and complexity of the problem of prenatal cocaine exposure and child outcome.

We are confident that with large, prospective, well-designed studies that include more sensitive tests for the early childhood and school-age period, the possible long-term effects of drug exposure will be discovered. Intervention strategies aimed at maximizing the developmental outcome of the drug-exposed child must include all of the known and suspected factors that comprise optimal development. ■

Barry Lester is director of the Infant Development Center at Women and Infants Hospital in Providence, RI. He is also professor of psychiatry and professor of pediatrics at the Brown University School of Medicine. Beata Napiorkowski, MD '99, Brown University School of Medicine, works with Dr. Lester in the Women and Infants Dept. Of Pediatrics.

Guest Commentary

Different

by Lynne Patnode Nadeau

I have revenge fantasies. In them my 10-year-old daughter is grown, poised and articulate. She is accepting a Pulitzer or Nobel prize. She has written the novel that has finally surpassed *The Adventures of Huckleberry Finn*; she has found the cure for one of the scourges of our time. Sitting in the front rows at the ceremony are the naysayers of her childhood — the neighbors who called her rude, the classmate's mother who asked what was wrong with her, the teacher who said, "She doesn't need to be as different as she is."

Julie was a bright, observant toddler who talked young and recognized much of the alphabet at 18 months old. However, true to a pattern I did not then recognize, she crawled and walked later than average, and she was never in a hurry to progress to the next physical skill. I first realized that Julie was different sometime in her third year. She was reticent with the other children in her play group and objected to anything or anyone new in her routine.

At first I thought "different" meant simply "different from me." Julie is reserved where I am gregarious, contemplative where I am verbal. I struggled hard with her temperament during this early period, learning to support her as best I could, learning to accept her weaknesses as well as her talents. Never have I done more difficult work.

> *In all things cerebral, she matured rapidly … But socially and emotionally she is immature and uncertain.*

At age 4 she taught herself to read, and the distance between Julie and her peers widened. In all things cerebral, she matured rapidly. Her standardized math scores have been at the top of the range, and as early as first grade, teachers called her a gifted writer. But socially and emotionally she is immature and uncertain. She frequently laughs at the wrong time or bursts into tears of frustration in school. Children value physical prowess above all else, and Julie, who only recently learned to ride a bike, does not fit in. Withdrawn and dreamy, she never showed much interest in the world of play dates and best friends. In the younger grades, her peers shrugged and resigned themselves to her ways, but at ages 9 and 10, their tolerance for her has declined. The boys no longer find her teasing social overtures funny. Now they are just annoying.

My daughter can be a torment to her teachers, wandering away during outdoor activities or pursuing her own interests in class. In second grade Julie kept an illustrated journal of classroom events. One entry described a pterodactyl that her teacher had hung from the ceiling. The accompanying illustration puzzled me; it was a formal arrangement of circles and squares with a looming shape in the center. Suddenly, I saw she had drawn a view of her classroom from just above the pterodactyl.

Intense and stubborn, Julie puts people off. She avoids making eye contact or shaking hands, except with people she knows well. Julie has taught me that the worst insult is to ignore someone. Adults find her unresponsiveness enraging, and they cannot forgive it. Last year Julie spent far too much time with the principal and guidance counselor.

Our culture claims to value the individual, the eccentric, the self-made person. And maybe we do, if she is an adult. But with children we stress conformity and teamwork. Kids like Julie confound our expectations. As a mother I walk a fine line between what my daughter needs and what the world needs from her. So we have worked hard on social skills. In the past year we have consulted a counselor, who assures me that nothing is wrong with my daughter. She is, as I have always suspected, simply not like other children her age. His guidance has improved what Julie can handle.

As she matures, she becomes more aware of society's requirements, and she understands better that she ignores them at her peril. She must acquire a veneer of social sophistication, a manner that comes naturally to most of us, if she is to manage in the world. But I don't kid myself. Julie is who she is. Quirky and creative, she has a core of strength and self-awareness of which I am deeply proud. I only wish that finding her way could be less conflicted and excruciating.

Last year, Julie's teacher asked the class what each child would wish for if he or she could have anything. Her classmates wanted money, cars, trips to Disney World, more wishes. Then the teacher asked for Julie's wish. She said, "I wish that people would grow wings and tails the colors of their personalities." That answer is the essence of Julie, and on it, I base my hopes for her future. ■

Lynne Patnode Nadeau lives in Antrim, NH, and teaches English composition at New Hampshire Technical College.

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special Issue: Teen Suicide

Cognitive characteristics predict adolescent suicide attempts

By Anthony Spirito, PhD

The rates of adolescent suicide have been increasing steadily for the last 40 years, with an increase of 30 percent from 1980 to 1992 alone.

Suicide attempts that do not result in death are also increasing in frequency. Surveys indicate that anywhere from 7 to 10 percent of adolescents report they have attempted suicide and, of these, approximately 2 to 3 percent receive medical care.

> ***Cognitive deficits, such as problem-solving and other cognitive distortions, appear in a significant portion of adolescent suicide attempters.***

For some adolescents, a suicide attempt is the result of impulsive behavior, typically in the face of significant stress. For others, a suicide attempt follows a course from passive suicidal ideation to serious consideration of suicide as an option, followed by active planning. For the latter group, the cognitive factors that contribute to suicidal behavior are particularly important to investigate.

The importance of an individual's cognitive constructs in understanding suicidal behavior is evident in various models that have been postulated regarding suicidal behavior. In our own model, and those developed by other research teams, pre-existing psychopathology, environmental factors and interpersonal problems are believed to affect thought processes and coping behaviors, which in turn lead to suicidal intent and behavior.

These cognitive factors, which include hope-

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Inside This Issue

Washington state initiates comprehensive suicide prevention program.
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How accurately children perceive symptoms of an impending asthma episode varies widely.
See page 4

Guest Commentary: Clinicians must act to protect youth from suicide.
See page 8

Coming next month:
Turning the spotlight of research on low-income children's social competence.

This month's client handout
Giving "rap music" a positive spin.

Bill focuses attention on teen suicide

This copycat suicide was reported in newspapers in May: Two French girls, ages 12 and 13, reportedly shot themselves in the head as their favorite rock star Kurt Cobain had in 1994. The gun was owned by one of the girl's fathers. The girls left notes saying they were in love with Cobain. They left behind friends who had tried to talk them out of committing suicide. Most of all, they left behind questions those around them will never be able to answer. Why?

This story and others like them have focused attention on the growing problem of teen suicide.

Even before this latest report of teen suicide from northern France, a U.S. Senate resolution was introduced last month by cosponsors Sen. Harry Reid (D-NV), whose father committed suicide, and Sen. Patty Murray (D-WA), asking Congress to recognize suicide, the third leading cause of death for young people ages 15 to 24, as a national problem. For the 15-to-24 group, the resolution points out, the suicide completion rate has nearly tripled in the last 40 years, while the completion rate for suicide in the general population has remained relatively stable.

According to the American Foundation for Suicide Prevention, the suicide completion rate for young people in the same age bracket has tripled for young men,

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Keep Your Eye On

... epilepsy drug risks.

An epilepsy drug that is known to cause side effects including a skin reaction similar to third-degree burns presents a greater danger to children than previously thought, doctors warn. Scientists at Glaxo Wellcome have discovered that side effects of Lamictal (lamotrigine) occur in between one in 100 to 300, rather than one in 1,000 cases, as previously thought. The company has issued a warning for doctors. The drug is considered a significant advance in the management of epilepsy. (*The Independent* via Individual Inc.)

... student pictures.

As part of a recent assessment of school environment, students at the Scott Middle School in Hammond, IN, were asked to draw pictures of their teachers at work. Much to the teachers' surprise, they were drawn at the blackboard with pointers, sitting at their desks in front of rows of desks (many without students). Seeing things through the students' lenses apparently was an eye opener because when students were asked six months later to draw the same scenes, teachers were shown more as facilitators, in groups and, more importantly, there were more children in the pictures. The picture-drawing strategy was developed by the Center for the Study of Testing, Evaluation and Education Policy at Boston College. For more information, call Scott Middle School at (219) 989-7340. (*School Board News,* April 8, 1997)

... no-cut teams.

Any student in Spokane, WA, under age 14 who wants to play on a school team is guaranteed a spot. The school district plans to spend $120,000 on new part-time coaching positions this year to meet the demand. While there may be some unusual practice schedules to meet demand, and some worry that the quality of the teams will go down, Frank Smoll, PhD, a sports psychologist at the University of Washington, says no child should be cut from a team before age 14. He addresses this issue in a book he co-authors, entitled, *Way to go, Coach!* Contact: Gary Livingston, superintendent, at (509) 353-5242 for information.

... cocaine's other view.

The American Optometric Association reports that children exposed to cocaine before birth may be more likely to develop crossed eyes than are other children. The crossed-eyes condition (strabismus) generally occurs in less than 4 percent of the population but researchers found that 27 percent of children in a recent study who had prenatal exposure to cocaine developed crossed eyes. The study was conducted at the Illinois Eye Institute at the Illinois College of Optometry and at Children's Hospital in Boston. Previous studies have determined that premature birth and low birth weight place a child at risk for crossed eyes.

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Grief turns into action in Washington state

One of the most comprehensive teen suicide prevention programs in the country began in Washington state when two parents' grief over their son's suicide turned into a grassroots effort to build a support system their son did not have.

"Many youth turn to suicide because of short-term crises, which overwhelm them. In particular, 15- to 19-year-olds tend to internalize the multiple stresses in their lives ... A Washington state study showed that many youth commit suicide, not because they want to die, but because they want one part of their lives to change. Unfortunately, most young people cannot properly handle their pressures alone — and this is why all youth are vulnerable to suicidal thoughts and actions," declared Sen. Patty Murray (D-WA), speaking at recent ceremonies in Washington, D.C.

Murray credited her home state's grassroots efforts spearheaded by Scott and Leah Simpson, whose son committed suicide in 1992 and whose efforts are now part of a comprehensive suicide prevention plan that recently received another two years' funding from the state legislature.

"Its strategy should be taken into account in developing a national agenda," said Murray, referring to the 115-page plan that was developed by the state's health department, using the resources of the University of Washington and an advisory council representing a variety of community organizations and interests. Here are a few highlights from the plan regarding the problem of youth suicide:

- Targeted at adolescents ages 15 to 19 and young adults ages 20 to 24, the plan ranks Washington State as 10th highest in the nation for youth suicides and notes that the problem of youth suicides is "predominately a problem of the Western States." Reasons for this are unclear but are under study by the Centers for Disease Control and Prevention, according to Gail E. Brandt, social and health program coordinator in the health department's injury prevention program.
- During the mid-1980s, Washington state's suicide rate among 15- to 19-year-olds rose 50 percent. Even though this upswing has stabilized, 325 young people between 15 and 24 committed suicide between 1990 and 1992, an average of two youth suicides a week. "This has been a pattern for the last 10 years," the report states.

Groups identified in the plan as high-risk include white males, Native Americans, high-achieving youth, gay and lesbian youth, and victims of abuse/assault.

Firearms are the most common method of youth suicide for both males and females. The report states: "Youth suicide tends to occur impulsively when vulnerable youth feel overwhelmed by undesirable life events, and have the opportunity — access to a lethal method, especially a gun, and lack of supervision." ■

From "Youth Suicide Prevention Plan for Washington State," January 1995.

A national model

Copies of the *"Youth Suicide Prevention Plan for Washington State"* are available from the Washington State Department of Health Injury Prevention Program by calling (360) 753-4112. For information about the plan, contact Gail E. Brandt, MPH, Washington State Department of Health, Injury Prevention Program, (360) 664-2173.

Adults may prevent teen suicides

Washington state's teen suicide prevention efforts carry a simple message for adults: Ask the question.

"Be direct about using the word suicide," says Gail E. Brandt, who coordinates the program for Washington's health department. Adults need to recognize that if a teen is thinking about committing suicide, it's not just a phase or a way of getting attention.

The message "I'm concerned about you ... are you thinking about suicide?" has been part of a widely publicized public-education campaign, now nearing completion.

Efforts have been directed at adults who are influential in the lives of young people to enable them to recognize signs of depression and possible suicidal behavior, and to intervene by letting youths know they will help them get help, says Brandt.

Among the key recommendations of the plan are to broaden school-based educational programs and conduct a statewide public-education campaign to reduce access to firearms and other lethal means of suicide. Family support training and skill-building to help at-risk youth manage moods, interpersonal communication, decision-making and help-seeking skills are important components of the plan.

The report contains a detailed list of prevention approaches, targeted audiences and evaluation outcomes.

BEST COPY AVAILABLE

Children's ability to detect asthma symptoms affects health outcomes

By Elizabeth L. McQuaid, PhD, and Gregory K. Fritz, MD

For some children, struggles with asthma symptoms can result in prolonged school absences and frequent visits to the doctor.

Intervention programs often seek to reduce asthma symptoms and lessen their impact by teaching children self-management skills to control episodes. Such programs often provide asthma education, such as information about the causes of asthma, and the appropriate steps necessary to treat asthma symptoms. However, a child's perceptual accuracy, or ability to notice signs and symptoms of an impending asthma episode, is a necessary prerequisite to appropriate self-management.

For school-aged children with asthma, who spend increasing time away from parents with peers and at school, perceptual accuracy likely plays a crucial role in beginning the self-management process. Recent research with this population demonstrates that children's ability to detect asthma symptoms varies widely, and has important implications for the course of their asthma treatment.

Summer camp research

Data regarding perceptual accuracy, psychological factors and asthma morbidity were collected at a summer camp setting. Eighty-six children with asthma, between the ages of 7 and 14, served as study participants. At the beginning of the camp session, children met with research staff to become oriented to the research procedure, which included familiarizing children with peak flow monitoring. This entails having the children breathe forcefully into a tube-like device, which then provides a measure of the child's lung functioning.

Throughout the two-week session, children met briefly with research staff three times daily around mealtime. At each brief session, children were first asked to estimate their peak flow value, which served as their subjective guess of their asthma symptoms. Then they engaged in a computerized peak flow task to obtain an objective measure of their pulmonary functions. This motivational computer task instructs children to blow forcefully into a spirometer ("blow down the brick wall") and is accompanied by music and a computer image of a hole in a brick wall that enlarges in proportion to the child's effort. Results from the computer task provide a measurement of the child's current degree of asthma symptoms.

An accuracy index for each child was then derived by computing the correlation between the subjective and objective estimates of peak flow over the course of camp. This provides a measure of how well the child's guess relates to his or her actual level of asthma symptoms.

Repressive copers rate higher

This method indicated a wide range of perceptual ability across children in the study. Although some children were highly accurate (subjective-objective correlation of above $r = .80$), a number of children had virtually no correspondence between their subjective ratings of asthma symptoms and the objective estimates of pulmonary function provided by spirometry.

In order to clarify some of the determinants of perceptual accuracy, researchers also collected information regarding each child's intellectual ability, anxiety level, coping style and behavior problems. Parents of children provided the research team with information concerning their own style of reporting physical symptoms.

Of these variables, both child intelligence and repressive coping style were found to be related to more accurate symptom perception. Child behavior problems, child self-report of anxiety and parent symptom-reporting style were not found to be related to children's perceptual accuracy for asthma symptoms.

The findings linking intelligence with accurate symptom perception suggest that general cognitive ability is likely a key factor in noticing signs of an asthma episode. This may be due to a better understanding of asthma, the meaning of peak flow readings or the symptom-reporting process in general. Alternatively, factors related to intelligence, such as the ability to concentrate and pay attention to symptom cues, may account for this relationship.

Lack of worry helps?

The fact that children with repressive coping style were found to be more accurate symptom reporters than other children was an unexpected and intriguing finding. One plausible interpretation is that repression, which may represent lack of worry about asthma symptoms in this sample, facilitates more accurate assessment of physical processes. In other words, it may be that a lack of extreme concern and panic about one's asthma allows for a more calm, objective

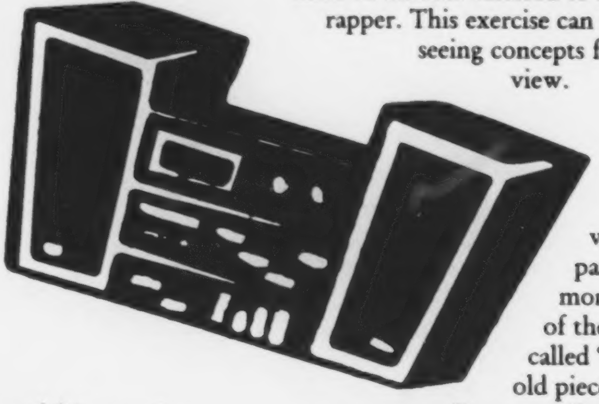
Give "Rap Music" a positive spin

Rap music has a largely negative reputation. This may or may not be deserved, but it probably contributes to the attraction it holds for so many of our young people.

Perhaps, if we listen closely, we adults can stop focusing on the negatives of Rap and see what positives can be drawn from it.

Music has been a source of conflict between generations throughout history. For example, parents feared the music popular with the youth of the '50s and '60s was going to bring about the downfall of civilization, but now we call it "oldies but goodies" and "classics."

As music and as society mature, our perception of what is art changes, and the way we relate to the music changes, too. If history continues to repeat itself, Rap is headed in a similar direction. Therefore, even if you do not like Rap, it may be worth the effort to develop a greater understanding of it as a way of enhancing your ability to communicate with the young people in your life.



Converse with respect

Rap's popularity can be useful in opening adolescents up to being more expressive. If you cultivate even a limited knowledge of Rap, a discourse about it can be a way of getting them to feel more relaxed, and then to open up and discuss various topics. Once adolescents feel relaxed, they may be more willing to discuss other topics they may have been reluctant to express.

Acknowledging that Rap is here to stay, and working toward discovering what we can learn from this, doesn't mean that you must like it. Young people won't expect you to like it. They are not likely to be offended if you say you don't like a certain song or artist, and they appreciate it if you have a better rationale for not liking that person or song than just saying, "I can't understand him" or "It's too loud."

Try to respect their feelings for an artist while letting them know you can also have an opinion. When approached on a level of mutual respect and understanding the interaction tends to be positive.

Real issues portrayed

Rap can be used as a way of introducing new topics and ideas. Much of Rap music portrays real life, and with a little research you can find the message and use it to discuss these issues. For instance, themes of machismo run through Tupac's "Hit 'Em Up". It can be used to discuss how "hood" influences may affect behavior.

Themes that degrade women can generate productive conversations that may encourage young people to put themselves in others' shoes. You may point out that they would not like to have their sister or mother referred to in terms used by the rapper. This exercise can help them get used to seeing concepts from a different point of view.

Samplings from the past

Rap also uses a variety of songs from the past as part of the harmony that makes the basis of the melody. This process, called "sampling," will inject an old piece of music and the artist Raps over it. Songs like Coolio's "Gangsta Paradise" used music originally written by Stevie Wonder. When young people hear this, they are generally amazed that their music borrows a melody or a bass rift made famous by older generations.

Many of the songs have a variety of messages that can be used as discussion points with our children. For instance, Bone Thugs and Harmony's "Crossroads" deal with images of violence, death and dying, grief and anger. These songs express the hopelessness many young people feel, but it also declares the hope that has been felt.

Don't make uninformed value judgments

It is interesting to see how these topics are

Continued on next page . . .

... *Continued from previous page*

interpreted by young people and what messages they draw from this music. We need to be open to these differences in interpretation and use them as discussion points rather than assuming that there is little value in the music overall. You may be surprised to find that the youth learn a thing or two from you in the process, and that you may learn some things as well.

The lyrics for most Rap songs can be obtained with minimal effort. The Internet is a good source of information, but music stores are also helpful. It is useful to know the lyrics even if you don't like the song. When you translate the lyrics into language you better understand, you may find the meaning changing.

In the same way, young people take what they need out of the music. A young person in need of violence may look for the violent content; a youth who is angry may relate to the anger; while a youth who is loved may simply seek out the entertaining aspects. We need to look at these issues more closely before we pass judgment.

Finally, if you think this advice applies only to the African-American parents who may have children listening to Rap, you should note that 70 percent of all Rap music is bought by whites. ■

By Deane Wiley, research assistant professor at Missouri Institute of Mental Health. This article was adapted with permission from the Parenting for Peace and Justice Newsletter, 4144 Lindell Blvd., Room 408, St. Louis, MO 63108.

The Brown University **Child and Adolescent Behavior Letter**

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assessment of symptoms. Future research will allow a more in-depth analysis of the link between various coping styles and asthma outcome.

When perceptual accuracy was examined in relation to health outcomes such as frequency of emergency room visits, school absences and sleep disruption due to asthma, some interesting findings emerged. Children who were less accurate at detecting symptoms were found to be more likely to have had a history of frequent emergency room visits, along with more school absences due to asthma symptoms. These results, although modest, argue that perceptual accuracy can influence asthma morbidity for school-aged children.

Further work is needed to better understand the determinants of perceptual accuracy, how perceptual ability changes with maturation, and whether poor perceivers can be trained to improve their perceptual accuracy. Ultimately, this work may constitute an important step on the road to improving the lives of children with asthma. ■

Elizabeth L.McQuaid, PhD, is a staff psychologist, Dept. of Child and Family Psychiatry at Rhode Island Hospital, and assistant professor, Dept. of Psychiatry and Human Behavior at Brown University. Gregory K. Fritz, MD, is director of Child and Adolescent Psychiatry at Rhode Island Hospital, and professor, Dept. of Psychiatry and Human Behavior at Brown University.

Recommended Reading

SOCIAL WORK PRACTICE WITH CHILDREN — *Nancy Boyd Webb (Foreword by Edward Zigler), Guilford Press, 390 pages, $35 (hardback); (800) 365-7006.*

Written by the editor of a new Guilford series of social work books, this volume provides social work practitioners and educators with resource material and methods for dealing with children who have encountered desperate life situations. The basics of social work practice are covered. The volume serves as a text and as a refresher for those already immersed in therapeutic relationships with disturbed children.

What's New in Research

Study identifies baseline viral load in pediatric AIDS

HIV-infected blood of perinatally infected infants peaks at one to two months of age and then slowly levels off at 24 months at relatively high concentrations, according to a recent study supported by the National Institutes of Health.

Peak viral loads at one month suggest that the majority of infected infants were exposed at the time of delivery. A small number of infected infants had high blood levels of HIV at birth, which suggests that they were infected in utero. The multicenter study suggests that babies with higher viral load might benefit from antiretroviral treatment.

Children with HIV viral loads greater than 299,000 (median level) virus particles per milliliter (mL) of blood during the first few months of life had a 44 percent probability of progressing to AIDS or death within the first 24 months of life. For those with less than 299,000 particles/mL the rate of progression to AIDS or death was only 15 percent.

According to Thomas C. Quinn, MD, senior investigator, of Johns Hopkins University, the dynamics of viral replication in these HIV-infected infants are distinctly different from those observed in infected adults. Following a dramatic rise in viremia in the first few months of life, the viral burden remains very high in contrast to the sharp decline usually observed in adults.

All of the infants in the study were born prior to the closing of the AIDS Clinical Trials Group 076 Study in which the administration of zidovudine during pregnancy, labor and to the newborn during the first few weeks of life was shown to significantly reduce the risk of HIV transmission.

"Viral load and disease progression in infants infected with human immunodeficiency virus-type 1," by W. T. Shearer, MD, PhD, et al., *New England Journal of Medicine*, 336(19):1337-1342, 1997. Requests for reprints should be directed to: Dr. Shearer, Texas Children's Hospital, 6621 Sannin St., MC 1-3291, Houston, TX 77030.

Many children exposed to cockroach allergens

Some of the nation's most vulnerable children are also suffering disproportionately from asthma as a result of exposure to cockroach allergens, a new study shows.

The five-year study followed 476 children with asthma living in eight metropolitan areas; most of the children were either African-American or Hispanic. Doctors found that children who were both allergic to cockroaches and exposed to high cockroach allergen levels were hospitalized for their asthma 3.3 times more often than children who were allergic but not exposed to cockroach allergen, or children who were exposed to high levels of cockroach allergen but were not allergic.

The combinations of allergy to dust mites or cats and high exposure to mites or cat allergen were not associated with more severe asthma symptoms in the study sample.

"The role of cockroach allergy and exposure to cockroach allergen in causing morbidity among inner-city children with asthma," by D.L. Rosenstreich, MD, et al., *New England Journal of Medicine*, 336(19):1356-63, 1997. Address reprint requests to: Dr. Rosenstreich, Albert Einstein College of Medicine, 1300 Morris Park Ave., Bronx, NY 10461.

Suicide attempters

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lessness, negative attributional style and problem solving, are believed to mediate the effects of these preexisting factors or to have direct effects on suicidal intent and behavior.

Cognitive processes at the time of the attempt are important to evaluate. In one of our studies, three primary aspects of suicide intent specific to adolescent suicide attempters emerged in a factor analysis of the Suicide Intent Scale. Two of the factors were primarily cognitive: they were labeled "expected outcome" and "planning activities," while the third we described as "isolation behaviors."

"Expected outcome" refers to expectations, purpose and perceived lethality of the suicide attempt. For example, in our study of almost 200 suicide attempters, about a third expected their suicide attempt would result in death. "Planning activities" include cognitions related to degree of premeditation and planning of the attempts.

Impulsive suicide attempts occurred in approximately two-thirds of the sample, while planned attempts were characteristic of about one-third of the group. We found that those adolescents who planned a suicide attempt were more hopeless and depressed and experienced significantly greater suicidal ideation than adolescents who made impulsive suicide attempts.

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Hopelessness versus depression

Hopelessness has been discussed by many as a particularly important contributor to suicidal behavior. Hopelessness, which refers to a negative attitude about future events, including a global expectation of negative future occurrences, has been found to be consistently higher in suicide attempters than in suicide ideators, nonsuicidal psychiatrically hospitalized adolescents and nonsuicidal adolescents in our studies. A number of studies, however, have shown that depression is more highly related to suicidal ideation than hopelessness, suggesting that hopelessness is more salient in attempters than in those who only think about it.

In one of our studies, hopelessness was more strongly related to suicide attempters than were other factors, including family dysfunction. Whether or not they are suicidal, female adolescents typically report higher levels of hopelessness than males.

Some adolescent suicide attempters also tend to have a negative attributional style; that is, they attribute undesirable events to themselves, to stable factors and to global causes more often than nonsuicidal adolescents do.

However, in general, suicide attempters do not appear to be very different from nonsuicidal psychiatric patients in their attributional style. In one of our studies, suicide attempters were more likely than nonsuicidal psychiatric patients to attribute good events to global causes and negative events to stable aspects of their environment. This negative attributional style may help explain the cognitive set related to suicide attempts.

Five steps to problem SOLVEing

The other common cognitive factor studied in suicidal adolescents is problem-solving. Several studies have shown suicide attempters to have poorer interpersonal problem-solving ability than nonpsychiatrically distributed adolescents. In addition, adolescent suicide attempters report greater deficits in the problem-solving process than other groups when confronted with problematic situations. They have difficulty generating alternative solutions and identifying positive consequences for problem solutions, and they have limited flexibility that inhibits the problem solving process: These adolescents are not typically able to progress through the various steps needed to adequately solve a problem.

The acronym SOLVE can be used to describe these steps: Select problem, Options, Likely outcomes, Very best one to do, and Evaluate and repeat as necessary.

Overall, it appears that cognitive deficits, such as problem-solving and other cognitive distortions, appear in a significant portion of adolescent suicide attempters compared to nonsuicidal adolescents. It is unclear whether these are temporary deficits evident at the time of acute stress or more stable characteristics. One study suggests the deficits may be temporary: Psychiatrically hospitalized suicide attempters did not differ from controls in their overall ability to generate solutions to standardized personal problems, but they used fewer coping strategies than controls in response to their most recent severe stressor.

A lack of cognitive flexibility, assuming more responsibility for negative outcomes than may be necessary, and rigidity in problem solving, especially interpersonal problem solving, are evident in many adolescent suicide attempters seen in therapy.

Specific treatment interventions

As part of the initial assessment of an adolescent who has attempted suicide, the cognitive characteristics discussed above should be assessed via an interview or by using measures designed to tap these characteristics. Cognitive therapy techniques to address cognitive deficits, along with problem-solving therapy to help teach adolescents new ways of conceptualizing their problems and generating alternatives, should be considered whenever clinicians identify these cognitive deficits in adolescents seen following a suicide attempt. Monitoring thinking patterns in order to teach the relationship between cognitions and both emotions and behavior is often necessary.

Challenging the validity of negative thought patterns is a technique often used for suicidal adolescents. Other techniques include decatastrophizing; that is, helping adolescent suicide attempters reevaluate whether they are overestimating the catastrophic nature of their problems. By exploring various possibilities, the therapist helps the adolescent view the situation as difficult, but not impossible.

Another technique involves scaling the severity of events (for example, from 1 to 100) to prevent the adolescent from conceptualizing everything as black and white. A third technique is to have the adolescent make a list of actions that might be taken in response to the suicide precipitant and then rank the actions from least difficult to most difficult. A discussion regarding the least difficult choices then ensues. This helps move the adolescent away from thinking of suicide as the only option to thinking of it as the worst choice among several options.

The cognitive strategy that has been advocated most among clinicians working with adolescent suicide attempters is problem solving. In problem-solving therapy, the adolescent is taught new ways to conceptualize the problem, consider solutions and plan a course of action based on this information. By working with the adolescent to approach problems one at a time and generate alternative solutions, a therapist can help restore hope in what appears to be a hopeless situation. ■

Anthony Spirito, PhD, is director of child psychology at Rhode Island Hospital in Providence, RI, and associate professor of psychiatry at the Brown University School of Medicine. He has conducted clinical research with adolescent suicide attempters for the past 12 years.

Bill

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doubled for young women and increased by 165 percent for young black men.

The resolution, which was unanimously approved by the Senate, was introduced as part of the nonprofit Suicide Prevention Advocacy Network's (SPAN'S) second annual national awareness event on May 3-6. A similar measure, which emphasizes the increase in suicide among minority populations, is expected to be introduced in the House by Rep. John Lewis (D-GA).

"It is time for this Congress and this nation to start talking about the issue of suicide," said Reid. "As someone who knows personally how devastating the suicide of a family member can be, I realize how uncomfortable and troubling it can be to talk about suicide. We need a national suicide prevention strategy." *(See related story on how Washington State is tackling its problem with teen suicide, page 3.)* Last month's event in Washington was organized by SPAN, founded by Jerry and Elsie Weyrauch after their physician daughter committed suicide. ■

For information, contact:

Suicide Prevention Advocacy Network, (888) 649-1366.

American Foundation for Suicide Prevention, (888) 333-2377.

Suicide Information and Education Center, (403) 245-3900.

American Association of Suicidology, (202) 237-2280.

Getting into the act

Three 20-second suicide prevention public-service announcements made by Mike Mills, the rock band R.E.M.'s bass player, are available for the cost of duplication and mailing. The audio messages are aimed at (1) a survivor who wants to do something about the problem, (2) a friend of someone who is talking about suicide and (3) a person who is suicidal. The tapes can be used with groups, one-on-one or as radio announcements. The cost is $5 per tape. For more information, call the Suicide Prevention Advocacy Network at (888) 649-1366.

Guest Commentary

Clinicians must become public-health educators on suicide prevention

By Alan L. Berman, Ph.D.

A colleague of mine refers to adolescents as "either large children or short adults with poor impulse control." Either way, they are vulnerable creatures, still needing external controls and limit-setting by older and wiser types to protect them from dangerous outcomes. Their vulnerability and their need for our governance are nowhere more evident than in the alarming and tragic statistics describing youth suicide.

As teen suicide rates have risen dramatically (311 percent for 15- to 19-year olds between 1950 and 1990), we have witnessed an equally impressive increase in our empirically based understanding of risk factors. Case-control psychological autopsy studies have documented a consistent picture regarding the prevalence of psychiatric morbidity (DSM diagnoses) and substance use, for example. For clinicians, these findings force our attention to risk assessment and early detection of the adolescent-at-risk.

> *More than 80 percent of firearm suicides by youth occur with a gun obtained in their own homes.*

Understandably, we are most comfortable with this approach as it fits the diagnose-and-treat model of intervention in which most of us were trained. Individual psychotherapy for the referred adolescent patient becomes the treatment of choice.

Unfortunately, a sizable proportion of adolescent suicides do not comply with this model. Many are difficult-to-treat youngsters who have revolving-door histories in the mental health system. Others come from dysfunctional and troubled family systems essentially incapable of aligning with caregivers and, too often, non-compliant with treatment recommendations. In this regard, we focus on the family, and family therapy becomes the intervention of choice.

The most significant intervention, however, is one that has the greatest likelihood of keeping the adolescent-at-risk alive long enough for our clinical interventions to have a chance of succeeding: making firearms unavailable to youth.

The Centers for Disease Control and Prevention confirms that the increase in youth suicide rates over the past several decades is largely related to the use of firearms as the method of suicide. Two-thirds of adolescent suicides now occur by means of firearms. Firearms are the means for suicide most commonly employed by females as well as males, by younger as well as older teens and by all races.

Our research has shown a strong relationship between the availability of firearms in the home and the risk for youth suicide. The risk increases as a gun in the home is kept loaded and unsecured; and this is true *even if the youth who completes suicide does not have identifiable mental health problems or recognizable risk factors for suicide.*

More than 80 percent of firearm suicides by youth occur with a gun obtained in their own homes. In the United States, firearms exist in one of every two households. Shockingly, more than half of parents who admit to keeping a gun in the home state that their firearm is *not* locked away from their children. Even among youth at high risk for suicide — males with a history of both a non-fatal suicide attempt and significant substance abuse — almost one in four reports that his family keeps a loaded firearm available to him in his home.

Whether planned or the result of an impulsive action, the use of a firearm to attempt suicide almost guarantees a fatal outcome. Thus, it is imperative that we earnestly strive to make a gun inoperable by and inaccessible to youth. Clinicians, youth workers and primary care physicians must develop a habit of routinely asking all families they counsel about the presence of and method of storage of firearms in the home.

We must remind ourselves, our patients and the communities in which we work what an invitation to immediate problem-solving a firearm is when it is essentially handed to an adolescent blinded by pain and despair, constricted in rationality and not yet sufficiently contemplative to delay impulsive action. We must act to protect adolescents long enough to give clinicians the chance to use their therapeutic skills to redirect lives toward healthier outcomes. ■

Allen L. Berman, PhD, is executive director of the American Association of Suicidology and senior author of Adolescent Suicide: Assessment and Intervention, published by the American Psychological Association.

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

What's New in Research

Poor children gain social competence from sensitive interaction with parents

By C. Cybele Raver, PhD

Developmental psychologists say that the stresses associated with poverty pose major threats to children's healthy social development. However, some investigators have argued that the increased focus on these risks is problematic: While it motivates us to recognize the developmental costs associated with the rising poverty rate among our nation's children, it also emphasizes deficits rather than strengths of low-income families.

Accordingly, researchers are examining the mechanisms supporting positive outcomes among low-income children in the context of high environmental stress. In particular, sensitive parent-child interaction has been argued to serve as a proximal, protective process in children's healthy social and emotional development, despite the risks associated with poverty.

> ***Sensitive parent-child interaction is a protective process, despite the risks associated with poverty.***

One way to examine the role of competent caregiving in the context of poverty is to focus on the quality of parent-child interaction as a predictor of low-income children's social competence, particularly as they make the transition from infancy to preschool.

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Inside This Issue

A mother's depression affects her newborn, but a touch researcher is developing some surprising interventions. *See page 3*

The time experts confirm what we already knew: Parents put in a full day. *See page 4*

Boys and girls use different strategies to solve math problems. *See page 4*

Commentary: A political scientist examines the politics of virtue. *See page 8*

This month's client handout
How to deal with a difficult child

Practical Matters

Good children, challenging behavior: How to regain authority

What do you do with a kid who's driving you nuts?

Child psychiatrist Stanley Turecki, MD, founder of the Difficult Child Program at Beth Israel Medical Center in New York, recently brought both his personal and professional expertise to bear on this question, often asked by parents and teachers.

As a self-described father of a difficult child, Turecki offered practical advice, if not specific solutions, on how to effectively parent a child who is frequently or habitually difficult. He spoke to an audience composed largely of somewhat tired-looking parents at the Emma Pendleton Bradley Children's Hospital in Providence, RI.

Turecki began his lecture by consoling parents, noting that although his own daughter was a difficult child, she grew up to be a healthy, happy adult. Likewise, he noted that there is often a connection between being a difficult child and being interesting and creative.

Behavior as a thinking style

Turecki's philosophy overwhelmingly stresses individuality and flexibility. He spent some

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Keep Your Eye On

... acting out.

What looks like typical teenage acting out may actually indicate a teen has attempted suicide, according to a study published in the June issue of *Pediatrics*. Researchers from Harvard Medical School reviewed data from the 1993 Massachusetts Risk Behavior Study, which involved more than 3,000 high school students. Unlike previous research, which linked suicide with depression and other psychiatric indicators, this study looked at risk behaviors such as not wearing a seat belt, smoking cigarettes or using smokeless tobacco, abusing drugs or alcohol, getting into physical fights, carrying a gun, and having unprotected sex after substance abuse. The authors, who said they conducted the study because of the dramatic increase in suicide rates among 15- to 24-year-olds, hope that by looking at risk behaviors, physicians can identify teens at risk for suicide attempts. With their model correlating teen risk behavior and suicide attempts, the researchers correctly identified which teens had made suicide attempts and which had not more than 92 percent of the time.

... new AAP president.

Longtime child advocate Joel J. Alpert, MD, FAAP, of Boston has been elected president-elect of the American Academy of Pediatrics (AAP). He will take office at the organization's annual meeting in October in New Orleans and will serve as the 1998-'99 AAP president. Alpert, who pioneered a pediatric residency at Boston City Hospital that linked community pediatricians and health centers with hospitals, says his goal is for "all children to have health coverage and access to needed health services." He is a graduate of Yale University and Harvard Medical School.

... antibiotic resistance.

Despite growing concern about resistance to antibiotics, parents increasingly request that pediatricians prescribe them for their children, according to a new study by researchers from Boston Medical Center. The study, published on *Pediatrics* electronic pages, surveyed 400 parents and 61 pediatricians and found that 18 percent of parents give their children antibiotics without consulting a physician. Nine out of 10 parents thought antibiotics were needed for ear infections; eight out of 10 thought antibiotics were needed for throat infections; and six out of 10 thought antibiotics were needed for cough and fever. "Growing bacterial resistance to antibiotics represents a global threat to the health of the world's population," the authors say.

... slip, slop, slap.

From the land down under comes the newest summer slogan, "Slip, slop, slap," to remind sun worshipers that sunscreen alone won't do the trick. The Australian message, conveyed in a recent American Academy of Pediatrics news release, reminds us to "slip" on a shirt, "slop" on the sunscreen, and "slap" on a hat. A recent large-scale study at Dartmouth Medical School found that

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only 20 percent of the 871 American children studied wore shirts and 3 percent wore hats for sun protection. Faces and legs are the areas most frequently omitted from sun protection, the study says.

... character ed.

High school students and adult sponsors from throughout Missouri convened in Jefferson City recently to discuss ways of improving the ethical climate in schools. Gov. Mel Carnahan, Republican Sen. Christopher Bond and Keith Nord, former team captain of the Minnesota Vikings, were among the speakers at the first Missouri Student Congress on Character Education. High school teacher Val Michael noted the change from 1971 when, as a new teacher, he was advised to stick to the subject matter and not teach ethics, *School Board News* reports. Students attending the conference were chosen by their principals for their leadership qualities and willingness to share ideas. For more information, contact Brent Ghan at (572) 445-9920, ext. 319.

Mother's depression passes to baby

Massage and other interventions counteract effect on development, researcher says

Researchers know that newborns of depressed mothers may also show signs of depression, and a variety of new non-drug interventions are helping mothers and their babies recover, a researcher says.

Based on more than two decades of research, Tiffany Field, PhD, director of the Touch Research Institute at the University of Miami Medical School, says that massage therapy, movement exercises such as tai chi, music therapy and interaction coaching are some of the methods successfully counteracting the effects of mothers' depression on babies.

Researchers estimate that 10 to 12 percent of pregnant women experience chronic depression. An estimated 40 to 70 percent of new mothers suffer from postpartum depression, caused by the radical post-birth changes in hormonal levels that can last up to three months. An additional 30 percent of women have long-lasting and severe postpartum depression.

Field's latest research on adolescent mothers with depression shows that their infants have biochemical profiles in which some neurotransmitters are elevated and others are depressed, affect is flat and activity levels are low. Field says the same holds true for adult women. However, techniques such as massage can alter levels of norepinephrine, which is elevated in depression, and dopamine, which is abnormally low.

One method of intervening with babies is tactile/kinesthetic stimulation, or massage therapy, for 15 minutes a day, two days a week, for six weeks. Norepinephrine and dopamine levels are tested in urine and saliva samples. Infants treated with this method show reduced stress hormones, sleep better, cry less and are generally more responsive.

Introduction of music into therapy and movement exercises such as tai chi are also useful for pregnant women and new mothers.

"Even though the mother is battling depression, she has to be actively involved in suppressing its effects on her child," Field says.

Another intervention to help improve interaction between depressed mothers and their depressed infants is interaction coaching in which the mother wears a small microphone in her ear. Mother and child are left to play together in an observation room while a coach gives the mother instructions on how to positively interact with her infant.

For mothers who are less active with their children, game-playing techniques are taught in order to generate activity and sharpen the infant's visual attentiveness. In cases where mothers overstimulate the infant, calming techniques are taught. All of the interactions are videotaped and given to the mother to practice at home.

The emphasis is to help the mothers deal with their own depression as part of their post-birth care, because research suggests that if depression continues into the child's sixth month, he or she can have growth and developmental delays at one year. These infants may be slower to walk, weigh less and be less responsive to people.

The worry is that, left untreated, these problems take hold in preschool and lead to behavior problems and aggressive tendencies later on. No one is sure about the long-term effects if depression is left untreated, but Field believes that the cycle can continue unbroken through adolescence and into adulthood. ■

For more information, contact Dr. Tiffany Field, director of the Touch Research Institute at the University of Miami Medical School, (305) 243-6790.

What's New in Research

Parents working overtime, time-use experts say

For all those parents who thought there weren't enough hours in the day for the job, the kids and some time to relax, you're right. Parents with two children spend about 7.5 hours a day, seven days a week, on child rearing according to W. Keith Bryant, PhD, a time-use expert from Cornell University. This is almost three times the amount experts had previously estimated, because earlier studies only considered primary child care. Now studies are adding all the time parents spend with their kids, while they're helping with homework, cooking, doing housework, working on hobbies, driving, eating, dressing and doing a host of other activities that fill the hours of modern households.

Bryant and colleague Kathleen D. Zick, PhD, of the University of Utah, used data from the 1975-1981 Time Use Longitudinal Panel Study, the 1977-'78 Eleven State Time Use Survey and the 1985 American Use of Time Data to analyze the hours two parents of two-children families spend raising their children to age 18. That's about 57,661 hours.

The studies were undertaken partly in response to parents who disbelieved earlier time-use experts who said parents spend only about an hour and 42 minutes a day in primary child care activities, says Bryant.

The research also makes little distinction between families with mothers who work outside the home and those with mothers who don't. When mothers don't work during the child-rearing years, the parents together spend about 7.7 hours a day on the children, compared to 7.3 hours when mothers work outside the home. That's a difference of about 23 minutes a day, the authors note.

Other highlights of the studies:

- Fathers of two sons spend 1,000 more hours with them sharing leisure time and 1,000 more hours in shared housework than do fathers with two daughters.
- When both children are girls, mothers spend 1,000 more hours sharing household work with them than mothers with two boys. Mothers spend the same amount of leisure time with their children whether they have boys or girls. "If sharing housework with children is an important way that children are taught to do household tasks, then it's not surprising that the historically gendered division of household work is so slow to change," Bryant says.
- Parents with higher incomes devote more time to child care than do lower-income parents.

The authors say there is no evidence that parents today spend less time with their children than they used to. In fact, the evidence is that they are spending more, Bryant and Zick report. A summary of their research was recently reported in Cornell's *Consumer Close-Ups.*

W. Keith Bryant, PhD, and Kathleen D. Zick, PhD, "An examination of parent-child shared time," *Journal of Marriage and the Family*, 58:227-237, 1996; "A new look at parents' time spent in child care: primary and secondary time use," *Social Science Research*, 25:1-21, 1996; and "Are we investing less in the next generation? Historical trends spent caring for children," *Journal of Family & Economic Issues*, 17:385-392, 1996. For reprints of the articles, write to Dr. Bryant at the Policy Analysis and Management Department, Cornell University, Ithaca, NY 14853.

Track Behavioral Health Trends

With baby boomers entering their 50s, attention to problems associated with older age is intensifying. And one of those problems is depression. Read about how demographic change is demanding better mental health services for the elderly in the latest issue of *Health Care Horizon*, a report on trends in behavioral health care delivery. To receive a free faxed copy of the publication, call Manisses Communications customer service at (800) 333-7771 and give us your fax number.

Math strategies differ in first-grade boys, girls

Gender differences exist in math strategies used by boys and girls as early as the first grade, but at that stage, the boys don't exert pressure on the girls to adopt their strategies, according to researchers from the University of Georgia. Researchers videotaped 58 first-graders — 30 boys and 28 girls — solving math problems individually and then again in a mixed-gender group.

Results showed that by January of their first-grade year, gender differences existed only in the way children approached problem solving, not in the number of problems solved correctly. In both individual and group settings, girls were more likely to use overt methods, such as counting on counters or fingers, to solve problems. Boys relied on retrieval skills, drawing on memorized answers.

As the school year progressed, researchers found that boys were more likely to increase their attempts to use retrieval even if they were not successful. Girls, however, seemed more concerned with being right and used such backup strategies as finger counting.

In group settings, retrieval,

Summer reading list

Sometimes our stock of good books exceeds our ability to provide extensive notice of their publication within a reasonable time from their publication. Thus, we take this opportunity to list volumes received that we think are very noticeable, with or without adequate space for a larger commentary, so that you might enjoy them during your summer respite. You can find them at your local bookstore, or call the publisher (the phone numbers are listed here) to place an order. Notice at this time does not preclude later use of the volumes in extended reviews.

— Lewis P. Lipsitt, Editor

Adolescence

Adolescence: Opportunities and Challenges, Vol. 7 of the Rochester Symposium on Developmental Psychopathology — *Dante Cicchetti and Sheree L. Toth, Eds., University of Rochester Press, Rochester, NY, 357 pages, $85 (hardcover), 1996, (716) 273-5778*

Transitions Through Adolescence: Interpersonal Domains and Context — *Julia A. Graber, Jeanne Brooks-Gunn and Anne C. Petersen, Eds., Erlbaum, Mahwah, NJ, 1996, 410 pages, $79.95 (hardcover, $36 prepaid, (800) 926-6579*

Group Work with Adolescents: Principles and Practice — *Andrew Malekoff, Guilford, New York, 1997, 336 pages, $36.95 (hardcover), (800) 365-7006*

Health Risks and Developmental Transitions During Adolescence — *John Schulenberg, Jennifer L. Maggs and Klaus Hurrelmann, Eds., Cambridge University Press, New York, 1996, 580 pages, $59.95 (hardcover), (800) 872-7423*

Puberty, Sexuality, and the Self — *Karin A. Martin, Routledge, New York, 118 pages, $55 (hardcover), $16.95 (paperback), 1997, (800) 634-7064*

Assessment

Linking Assessment and Early Intervention — *Stephen Bagnato, John T. Neisworth and Susan M. Munson, Brookes, Baltimore, 1997, 428 pages, $44.95 (paperback), (800) 638-3775*

Theory and Assessment of Stressful Life Events — *Thomas W. Miller, Ed., International Universities Press, Madison, CT, 350 pages, $55 (hardcover), 1996, (800) 835-3487*

Child Welfare

Child Welfare Research Review, Vol. 2 — *Jill D. Berrick, Richard Barth and Neil Gilbert, Eds., Columbia University Press, New York, 313 pages, $65 (hardcover), 1997, (800) 944-8648*

The Anthropology of Youth and Child Care Work — *Rivka A. Eisikovits, Haworth Press, Binghamton, NY, 102 pages, $32.95 (hardcover), 1996, (800) 342-9678*

Interviewing Young Children about Body Touch and Handling, a monograph in the Society for Research in Child Development series — *Margaret S. Steward and David S. Steward, Eds., University of Chicago Press, 235 pages, $19.50 (paperback), 1996, (800) 621-2736*

Families and Friends

Family and Human Development across Cultures: A View from the Other Side — *Cigdem Kagitcibasi, Erlbaum, Mahwah, NJ, 1996, 233 pages, $49.95 (hardcover), $22 (paperback), (800) 926-6579*

Family-School Links: How Do They Affect Educational Outcomes? — *Alan Booth and Judith F. Dunn, Eds., Erlbaum, Mahwah, NJ, 1996, 300 pages, $59.95 (hardcover), $29.95 prepaid, (800) 926-6579*

Families in Recovery: Coming Full Circle — *Carolyn S. Brooks and Kathleen F. Rice, Brookes, Baltimore, 333 pages, $34 (paperback), 1997, (800) 638-3775*

Stress, Coping, and Resiliency in Children and Families — *E. Mavis Hetherington and Elaine A. Blechman, Eds., Erlbaum, Mahwah, NJ, 1996, 245 pages, $59.95 (hardcover), $22.50 prepaid, (800) 926-6579*

Ordinary Families, Special Children: A Systems Approach to Childhood Disability, Second Edition — *Milton Seligman and Rosalyn B. Darling, Guilford, New York, 324 pages, $30 (hardcover), 1997, (800) 365-7006*

The Company They Keep: Friendship in Childhood and Adolescence — *William M. Bukowski, Andrew F. Newcomb and Willard W. Hartup, Eds., Cambridge University Press, New York, 426 pages, $59.95 (hardcover), 1996, (800) 872-7423*

Social Motivation: Understanding Children's School Adjustment — *Jaana Juvonen and Kathryn R. Wentzel, Eds., Cambridge University Press, New York, 375 pages, $49.95 (hardcover), $29.95 (paperback), 1996, (800) 872-7423*

Psychopathology

Gender Identity Disorder and Psychosexual Problems in Children and Adolescents — *Kenneth J. Zucker and Susan J. Bradley, Guilford, New York, 440 pages, $45 (hardcover), 1995, (800) 365-7006*

Developmental Psychopathology: Perspectives on Adjustment, Risk, and Disorder — *Suniya S. Luthar, Jacob A. Burack, Dante Cicchetti and John R. Weisz, Eds., Cambridge University Press, New York, 618 pages, $69.95 (hardcover), $27.95 (paperback), 1996, (800) 872-7423*

Mindblindness: An Essay on Autism and Theory of Mind — *Simon Baron-Cohen, MIT Press, Cambridge, MA, 1995, 171 pages, $22.50 (hardcover), (800) 356-0343*

Substance Abuse

Alcohol Misuse: A European Perspective — *Timothy J. Peters, Ed., Harwood Academic Publishers, Amsterdam, 200 pages, $68 (hardcover), $27 (paperback), 1996*

Therapy

Developmentally Based Psychotherapy — *Stanley I. Greenspan, International Universities Press, Madison, CT, 1997, 462 pages,* $65 (hardcover), (800) 835-3487

Principles of Behavior Analysis — *Julian C. Leslie, Harwood Academic Publishers, Amsterdam, 357 pages, $64 (hardcover), $25 (paperback), 1996*

Growing a Therapist — *Jeffrey A. Kottler, Jossey-Bass, San Francisco, 215 pages, $26.95 (hardcover), 1995, (415) 433-1767, ext. 596*

Violence

Children in a Violent Society — *Joy Osofsky, Ed., Guilford, New York, 338 pages, $38.95 (hardcover), 1997, (800) 365-7006*

Understanding Violence — *Elizabeth Kandel Englander, Erlbaum, Mahwah, NJ, 1997, 187 pages, $45 (hardcover), $19.95 (paperback), (800) 926-6579*

Miscellaneous

Children Talk about the Mind — *K. Bartsch and Henry M. Wellman, Oxford University Press, New York, 234 pages, $45 (hardcover), $19.95 (paperback), 1995, (800) 451-7556*

Steps to Independence: Teaching Everyday Skills to Children with Special Needs — *Bruce L. Baker and Alan J. Brightman, Brookes, Baltimore, 383 pages, $26 (paperback), 1997, (800) 638-3775*

Learning to Listen: Positive Approaches and People with Difficult Behavior — *Herbert Lovett, Brookes, Baltimore, 269 pages, $23 (paperback), 1996, (800) 638-3775*

Words, Thoughts, and Theories — *Alison Gopnik and Andrew N. Meltzoff, MIT Press, Cambridge, MA, 268 pages, $30 (hardcover), 1997, (800) 356-0343*

Adult Bullying: Perpetrators and Victims — *Peter Randall, Routledge, New York, 183 pages, $17.95 (paperback), 1997, (800) 634-7064*

Altering Fate: Why the Past Does Not Predict the Future — *Michael Lewis, Guilford, New York, 238 pages, $22.95 (hardcover), 1997, (800) 365-7006*

Necessary Illusion: Art as Witness — *Gilbert J. Rose, International Universities Press, Madison, CT, 1996, 148 pages, $27.50, (800) 835-3487*

The Difficult Child

Why is one kid easy-going, while her brother is just plain difficult? It's probably a combination of a lot of factors, including genetics and environment. But you can prevent some of the struggles with the most difficult child — without losing your authority as a parent.

You're in a restaurant — the first time you've eaten out in seven months — and Christopher will not sit still. He's seesawing on the edge of the booth, he's spilled his water — twice — and now he's yelling loudly that his sister is a great big fat booger nose.

If only Stella Chess were here: the grande dame of child psychology, the professor at New York University Medical Center who, with her husband and fellow child psychiatrist, Alexander Thomas, pioneered research in children's temperament. What would Dr. Chess say?

"To say, 'We'll take you home and punish you' would not be very much help. To say, 'No, you mustn't do that' would also not be very much help," says Dr. Chess, who, though retired, still consults researchers and clinicians. "Essentially what you'd say is, 'Do you want to come out to dinner with us? Because you don't have to come — we can arrange for you to stay home if you want to.' Not, 'You rotten little twit, if you can't behave yourself, we'll leave you home.' But put it in terms of 'Do you wish?' So that anything that the parents do would now be in terms of an alliance with the child."

Parents can also help prepare children for unfamiliar situations by gradually introducing them to new things, such as different foods or restaurant table manners. "Give a list, just the way you would to a kid you're taking to a baseball game. 'You don't throw the hot dogs around.'"

Kids are kids — and Dr. Chess knows this from nearly a half-century of studying hundreds of children. Even when you've done everything right, and Christopher has accepted a non-confrontational invitation to dinner and you've explained all the standards of public behavior in a quiet but firm way, still, there he is, blowing his straw wrapper at the perfectly behaved child at the next table.

In that case, says Dr. Chess, someone should take Christopher home, without presenting it as either a punishment or a reward.

The key is not to get in a blinking match with your kid. "I'd have parents come to me and say, 'I say black, he says white,'" she says. But when Dr. Chess questioned further, she would find that parents had successfully been able to keep their children from running into the middle of the street. "That immediately tells me that this is not a totally oppositional kid, that this child is capable of learning something when there's consistency," she says.

In an ongoing study Dr. Chess and Dr. Thomas began in 1956, one in 10 children had a so-called "difficult" temperament. These high-intensity kids hated anything new, kept erratic sleeping and eating habits and were frequently in bad moods.

How not to shout

When your kid is driving you crazy, the natural response is to yell at him or her when something happens. But that's the wrong time, says child psychiatrist Stanley Turecki, MD. He recommends "planned discussions" — a time set aside with the specific purpose of identifying problems and coming up with solutions together. "Reassure the child that she will not be punished or lectured to," says Turecki, founder of the Difficult Child Program at Beth Israel Medical Center in New York City. "You are on his side and want him to participate." He says planned discussions should be serious and firm, but kind and brief, and that parents should clearly define rules and expectations. Check to see if the child understands by asking him or her to repeat what's been said. "Finish by asking the youngster to do his best," he says. "This is an extremely powerful inducement."

Continued on next page

About one in six kids were called "slow to warm up." They also tended to withdraw from the new, and were slow to adapt to change, but their negative emotional reactions were far less intense than those of their "difficult" peers. A casual observer would probably call these kids shy.

Two-fifths of the children in the study were parents' dreams: the ones with easy temperaments, willing to try new things, quick to adapt to change, and usually in good moods.

Whether a child's temperament is in his genes — and there is research to show that temperament has a genetic component — it is not fixed like the color of his eyes.

"While temperament usually has a general continuity over time, it also has some degree of plasticity: It can change," says Dr. Melvin Lewis, professor of child psychiatry and pediatrics at the Yale University Child Study Center. "It can change for internal reasons that don't remain totally the same, and it can change because of interactive reasons. Interaction with the environment brings out differerent aspects of the child's temperament. Severe difficulties in the environment may well change the nature of the child's temperament. Thus, though there's a certain degree of continuity, it is not fixed immutably."

Knowing your child's temperament may be the first step toward a harmonious household — and a better "fit" between a child's temperament and his or her environment. "In many child psychiatry inpatient services, while they may not be able necessarily to 'cure' the child, a major goal may be to help improve the interaction between parents and their children, to improve the goodness of fit," says Dr. Lewis, who edited a widely used textbook on child and adolescent psychiatry.

"The point is to know the child's temperamental qualities and don't ask something impossible, like getting used to a new situation all at once," Dr. Chess adds.

This holds true even if your child has been blessed by an easy temperament. "The problem there might be that this kid is going to be too eager and sign up for every extracurricular activity and get an impossible schedule, in which case you could get into an oppositional situation," she says.

How do you handle a situation like that?

You tell the child: You can try out all of these things, but then you have to pick two because you have to leave time to study. "And say it quietly, not yelling, but be firm about it," Dr. Chess advises. "It's still true that parents should know more about what's good for the child than the child."

Some parents bristle at the idea of approaching situations from the child's point of view. But the point is not to look at parent-child relationships as a contest: It's to respect the child's temperament in his or her efforts to master social necessities.

The good news is that most kids turn out just fine. "In a great number of our cases, in the end, the difficult temperament did not lead to disaster," Dr. Chess says. "Kids with what we call the difficult temperament, once they have gradually learned to adapt to the world, are much more fun to be with. They bring zest to situations." ♦

The Brown University Child and Adolescent Behavior Letter

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which is the boys' preferred strategy, dominated the group work. Boys, however, did not ridicule girls for counting on fingers.

Although lead author Martha Carr, PhD, believes social pressure is there, it isn't coming from the boys. "Insight into how girls and boys approach mathematics and the factors that affect these different approaches might increase our understanding of the causes of later developing gender differences in mathematics, the authors conclude.

"Gender differences in first grade mathematics strategy use: social and metacognitive influences," Martha Carr, PhD, and Donna L. Jessup, PhD, *Journal of Educational Psychology*, 89:318-328, 1997. For reprints write to Dr. Carr, Educational Psychology Department, University of Georgia, Athens, GA 30602.

Looking stupid is the hardest math problem

By the time middle school rolls around, looking stupid in math class by asking for help is the one problem you want to avoid. But competition and fear of what others will think, not gender, appear to be the silencing factor. Researchers at the University of Michigan questioned 203 middle schoolers to find out what motivates them to seek help in math class. When they reviewed the findings, they found students who were not doing well were least likely to ask for help. These kids were more likely to be competitive students and more worried about what others thought than those students concerned with their own learning and understanding of the subject.

"Should I ask for help? The role of motivation and attitudes in adolescents' help seeking in math class," Allison M. Ryan, MA, and Paul R. Pintrich, PhD, *Journal of Educational Psychology*, 89:401-402, 1997. For reprints write to Ms. Ryan, 1400 School of Education Building, 610 East University, University of Michigan, Ann Arbor, MI 48109.

Recommended Reading

THE BIRTH OF HATRED: DEVELOPMENTAL, CLINICAL, AND TECHNICAL ASPECTS OF INTENSE AGGRESSION — *S. Akhtar, S. Kramer & H. Parens, Eds., Jason Aronson, Northvale, NJ, 172 pages, $27.50 (paperback), (800) 782-0015*

Perhaps one of the most compelling topics of our time, hatred does not receive enough research attention, and too often individuals with intense hatred do not receive clinical attention before the negative consequences, for others, of their condition are discovered. This volume, with succinct and wise chapters by the editors and other experts, including Harold Blum and Otto Kernberg, provides fascinating insights and helpful therapeutic direction.

CHILDREN IN TIME AND PLACE — *G.H. Elder Jr., John Modell and R.D. Parke, Eds., Cambridge University Press, New York, 290 pages, $16.95 (paperback), (800) 872-7423*

Part of a series on studies in social and emotional development, this volume features the study of major historical events, like the Depression and various wars, on children's development. Among the outstanding authors included, besides the editors, are Sheldon White, William Kessen, Michael Zuckerman, Emily Cahan, Brian Sutton-Smith, Robert Siegler and Tamara Hareven.

LEAVING HOME: THE THERAPY OF DISTURBED YOUNG PEOPLE — *Jay Haley, Brunner/Mazel, New York, 332 pages, $39.95 (hardcover), (800) 825-3089*

The second edition of an effective volume by a celebrated family and adolescent therapist includes two new chapters: one on young psychotic clients, the other a landmark chapter reporting that almost half of the adolescents who are diagnosed as schizophrenic live essentially normal lives when they are older.

ANNUAL PROGRESS IN CHILD PSYCHIATRY AND CHILD DEVELOPMENT, 1996: A SELECTION OF THE YEAR'S OUTSTANDING CONTRIBUTIONS TO THE UNDERSTANDING AND TREATMENT OF THE NORMAL AND DISTURBED CHILD — *M.E. Hertzig and E.A. Farber, Eds., Brunner/Mazel, 608 pages, $69.95 (hardcover), (800) 825-3089*

This is a long-standing, successful annual that reprints some of the best journal articles of the year, and this year contains contributions from Esther Thelen, Nathan Fox, Michael Rutter, David and Patricia Mrazek, Gerald Koocher, Dante Cicchetti, David Reiss, Robert Plomin, Andrew Meltzoff and many others. The volume's major virtue is that the selected articles have been hand-picked as especially worthy for anyone wishing to see the fine level of developmental studies published recently on attachment and parenting, and on developmental, clinical and treatment issues.

EMOTIONAL DEVELOPMENT: THE ORGANIZATION OF EMOTIONAL LIFE IN THE EARLY YEARS — *L. Alan Sroufe, Cambridge University Press, New York, 263 pages, $49.95 (hardcover), (800) 872-7423*

Authored solely by Sroufe, an outstanding authority on the topic, this volume is a comprehensive, state-of-the-art and -science of emotional development. Connections among cognitive, social and emotional processes are illuminated with fine, interesting, well-referenced writing.

Social competence

from page 1

In early infancy, children gain important skills in regulating their emotions in the context of synchronous, socially contingent interaction with their caregivers. This can extend through later infancy and early childhood. For example, in activities as routine as directing and maintaining their children's visual attention on objects and toys, parents may be simultaneously providing their toddlers with important practice in competent emotion regulation. By distracting infants out of bad moods and into positive states through joint attention, parents may provide toddlers with practice in marshaling attention to regulate their own affect.

The delay task

In a study recently completed in New Haven, CT, I examined the importance of this kind of sensitive interaction between parent and child among 47 low-income 24-month-olds and their mothers. Specifically, toddlers who participated in more socially contingent periods of joint attention with mothers during free play were expected to be more effective in regulating negative emotions.

To assess their effectiveness in regulating their emotions, children were offered a new toy as a gift. Instead of handing it to the child however, the experimenter placed the toy within view but out of the child's reach, explaining that the child could have the toy when she returned in a few minutes.

Children's use of four strategies — distraction with other objects in the room, self-soothing, comfort-seeking from the caregiver and focus on the prohibited gift — were analyzed from their behavior during the six-minute delay. In addition, the role of temperament in children's ability to modulate their emotions was considered. Children who were more prone to negative emotionality were expected to have greater difficulty using effective regulator strategies during the delay task. To test this hypothesis, children's negative emotionality was assessed during a short, two-minute separation from their caregivers earlier in the lab visit.

The study's results suggest that children who spent more time in joint attention with their mothers in free play were able to use more effective strategies, such as self-distraction, during the delay period. The dyadic measure of joint attention remained significantly predictive of children's use of these self-regulation strategies even after toddlers' temperamental predisposition to negative emotionality was statistically taken into account. Through bouts of joint attention with parents, children may gain experience in deploying their own attention to modulate their distress.

Girls seek comfort more than boys

But children's temperament also played a role in their ability to self-regulate. Those children who were particularly prone to distress during maternal separation spent less time using effective self-regulatory strategies during the delay task than did other toddlers. Gender differences in children's regulatory behavior during the delay task were also found. Specifically, girls sought more comfort from their caregivers than did boys, while boys spent more time distracting themselves with other objects in the room than did girls.

While girls and boys showed somewhat differing styles of self-regulation, on average, they did not show significantly more distress, suggesting that both styles of self-regulation were effective in aiding children from becoming overly distressed.

In sum, these findings lend preliminary support to the hypothesis that parental socialization of effective regulatory strategies, particularly of attention-directing strategies, plays a key role in young children's acquisition of effective self-regulation skills among low-income families.

Continuing research

This study represents a first step in examining the multiple mechanisms that help children in their efforts to make the transition from home to the preschool environment. My colleagues and I are continuing to research ways that parents and young children jointly structure routine social interactions.

We aim to gain a clearer understanding of the ways that parents actively socialize their children's emotion regulation, and of the role of children's emotion regulation for their social competence with peers.

We want to find out, for example, if children who use more effective self-regulatory strategies in laboratory contexts go on to demonstrate more emotional equilibrium when faced with conflict with a peer. Also, do parents who report different styles of emotional expressiveness stress qualitatively different behavioral strategies to deal with their children's regulation of emotions?

In addressing these questions, we are particularly interested in ways that nurturant caregiving represents a wise investment made by parents facing financial disadvantages in their children's healthy social development.

We also hope to contribute substantively to the growing field of social development by bridging the empirical gap between disparate areas of research on parenting and children's social competence.

The investigation of low-income children's normative development offers two benefits: It strengthens our knowledge of basic developmental process, and it improves our understanding of ways to foster positive social outcomes in conditions of risk.

C. Cybele Raver is an assistant professor of human development and family studies at Cornell University. For more information, contact Dr. Raver at (607) 255-4133.

Behavior

from page 1

time and energy dispelling the myth of the normal child, noting that even a diagnosis of attention-deficit disorder is, in actuality, more a grouping of behaviors than an objectively quantifiable diagnosis. "Be careful to realize that the boundaries between 'normal' and 'abnormal' are difficult to define," said Turecki, an assistant clinical professor at Mount Sinai School of Medicine. "Treat behavior as a thinking style, not pathology."

Contemporary psychiatry has gone overboard in its predilection for aggressively diagnosing psychological difficulties as if they were somatic illnesses, Turecki said, attributing the trend to psychiatry's effort to be a hard science. To make his point, he noted the near exponential swelling of the new edition of the DSM.

He bemoaned the country's "shrinking population of normal individuals" and noted that psychological over-diagnosis may be even more prevalent in pediatric psychology than in its adult counterpart.

Calling all experts

Do you have expertise in behavioral health that others should know about? This year's edition of the *Behavioral Health Yearbook* will include listings of individuals and firms with behavioral health consulting experience. The listing is **free**. For details, call Manisses Communications customer service at (800) 333-7771, and we'll fax you information and a form.

"I don't know what it's like in Providence, but in New York we have only gifted or learning-disabled children," he said, and received a chorus of sympathetic laughter.

Turecki stressed the importance of employing a "temperamental model" based on the premise that children each have their own genetically programmed sensory thresholds and typical styles for responding to new things as well as individual levels of activity, self-control, concentration, intensity, regularity, persistence and adaptability. He advises fathers and mothers to modify their parenting strategies to suit the individual needs of their children. "It always comes down to parents' expert knowledge of their child."

> *'I don't know what it's like in Providence, but in New York we have only gifted or learning-disabled children.'*
>
> **Stanley Turecki, MD**
> **Beth Israel Medical Center**

Turecki noted that as a therapist, he always relies on a parent's judgment, with the exception of extreme circumstances in which a child's welfare may be at stake.

Some places are hard to live in

Environment plays a big role in the making of a difficult child, Turecki said. For example, he noted that a child with a naturally temperamental disposition, one who might be classified difficult or hyperactive while living in a small, expensively furnished apartment in New York City, and going to a high-pressure private school, and whose parents are opera singers, might have a completely different experience under less physically and emotionally cramped circumstances.

In both disciplining and dealing with a difficult child, Turecki recommends that parents take charge by adopting a strategy in tune with a child's biological rhythms. He suggests making a difficult child into a junior partner with whom certain, more acceptable patterns of behavior and routines can be negotiated.

Parents and children can get into a vicious cycle of bad behavior and punishment, which not only soon renders the punishment ineffective, but becomes the natural way of interacting. As a parent, Turecki cautions, "Don't get mad; get earplugs."

Appropriately channeling a child's natural energies can be rewarding. For example, a finicky eater should be encouraged to choose and help in the preparation of her own food. Some of these children become great chefs, says Turecki. Likewise, if properly nurtured, ex-ADHD children might easily find success and happiness as stockbrokers in their adult lives. ■

For more information on Dr. Turecki's strategies for dealing with a difficult child, see his books *The Difficult Child* and *Normal Children Have Problems, Too*, published by Bantam Books. To order, call (800) 223-6834.

Guest Commentary

Life, liberty and the pursuit of morality

By James Morone, PhD

The most influential men in America met in Boston. The nation faced a terrible moral crisis: rampant substance abuse, sex, illegitimacy. Schools were languishing, the pursuit of profits was appalling, the explosion of lawsuits completely out of hand. Worst of all, parents were doing a terrible job raising their kids — not enough discipline. "Most of the evils" that afflict our society, reported the conference, stem from "defects as to family government." The gathering published a famous call for moral reform in 1679.

More than 300 years later, the old jeremiad is still doing a brisk business. From every corner we hear the same story: Moral failures vex the nation. But the moral diagnosis is wrong and its political consequences are pernicious. The moralizing divides Americans into a righteous "us" and a malevolent "them." Once these lines are drawn, you can forget about social justice, progressive thinking or universal programs. Instead, the overarching policy question becomes, "How do we protect ourselves and our children?" Never mind health care or welfare — build more jails.

Contemporary moralizing stands in a long, unhappy American political tradition. When economic and social problems are transformed into declining moral standards, the hunt is on for the immoral people who threaten the public good. There are always plenty of suspects, although the current list is particularly skewed toward single moms and drug abusers. In the tumult of their witch hunts, Americans ignore an alternative moral tradition that aspires, with Abraham Lincoln, "to touch the better angels of our nature."

The vice squad, which includes the likes of conservative politicians and writers, right-wing preachers and pundits, has constructed a simple story. Most Americans are good, but we are surrounded by rampant immorality. And that tide of misbehavior threatens America in fundamental ways. This lamentation has three effects.

First, the moralizing reassures. Good people are not to blame for social or economic troubles. The message resonates precisely because most Americans do consider themselves decent, religious and moral.

Second, the moralizing message drafts readers into a political fight. Each preacher would muster us into a somewhat different battle line in the great American culture war. Popular fronts include illegitimacy, divorce, crime, welfare, educational discipline, affirmative action, teen pregnancy, Satan, moral permissiveness, abortion, drugs.

Third, the message engages an enemy. And with this we arrive at the crux of the matter. The political result is a great division: a virtuous us, a vicious them. "They" threaten us; "they" are ominous, cruel and depraved (I'm not making these words up). In the real world of political passions, fine distinctions among the issues get lost in the tumult. The outcry against sin leads, willy-nilly, to the fight against sinners. What we get is the logic of the witch hunt.

The social diversions get especially intense when sins are projected onto racial and ethnic groups. Then the hidden question becomes: Are these strange people going to slip their moral aberrations into our cultural mainstream?

American racial history is a long, unhappy example. White southerners constructed an image of the former slaves as morally unprepared for freedom. The calumny included a standard roster of vices — laziness, dishonesty, thieving, political corruption. But the heart of the matter, endlessly repeated, was the supposed sexual lust of black men. In his popular history *The Tragic Era*, Claude Bowers reported the prejudice as fact: "Rape is the foul daughter of Reconstruction." As Bowers told it, the story ended happily, virtue triumphant. When "the Klan began to ride ..., white women felt some sense of security."

Fast-forward this stereotypic paradigm to the most active battle line in the contemporary morality crusades, the war on drugs. African-Americans constitute 12 percent of the population and an estimated 13 percent of American drug users. They account for 35 percent of arrests for drug possession, 55 percent of all convictions for possession, and a whopping 74 percent of all prison sentences. The effect of the war on drugs is to clear streets of young black men, and tough sentences will keep them off the streets.

The story of moral depravity is well-worn. Americans have survived their own unprecedented wickedness many times. The moralizing routine was already old when the Synod of 1679 published its lists of sins. The real threat is not moral decline. It is what Americans do to their own society in the name of arresting moral decline.

James Morone is a professor of political science at Brown University. He is currently working on a book about sin and politics, from the Puritans to the Clintons.

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Policy Issues

Infant/toddler care, education lags behind pre-school care

By Eleanor Stokes Szanton, PhD

As brain researchers have recently shown, infants' and toddlers' brains are developing at an enormous rate — faster than they ever will again — and in conjunction with their early experiences. If infants and toddlers are to start developing into well-adjusted human beings, eager to learn, those experiences must be carefully tailored to their interests, temperaments, states and individual abilities to process and respond. They are developing working models for who they are, how important they are, and how they relate to others. Ethnic identity is part of this process.

Our nation's lack of concentration and concern for millions of our infants and toddlers ... amounts to national child neglect.

At the same time, we have learned that caring for infants and toddlers in groups does not just come naturally, even for individuals who have been successful parents. Specialized training is required.

Finally, we have learned just how much infants' and toddlers' development is affected by the degree to which their families are under stress or are part of a network of social support. Child care and related services, functioning as a team, can be part of this support. Parents, and thus their children, can benefit a lot from feeling that teachers and caregivers are on their "team," helping them foster their children's development.

Status of infant and toddler care

It stands to reason that individualized care, such as

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Inside This Issue

IV clomipramine may bring rapid relief for depressed adolescents. *See page 3*

Rural or urban students have no trouble finding alcohol and drugs. *See page 3*

Store clerks are more likely to sell cigarettes to black children than to white children. *See page 3*

Commentary:
We excel in high technology, but can't pull our children from the grip of poverty. Why? *See page 8*

This month's client handout
Signs of sexual abuse in young children

Teen Pregnancy

Program stops generational pattern of childhood abuse, teen pregnancy

By Harriet Meyer

Academic and clinical literature makes clear that the childhood experience of sexual abuse has profound, long-term influences on the thinking and behavior of victims. Many years ago, a Chicago-based group called Heart to Heart, supported by the Ounce of Prevention Fund, found that a surprisingly large number of teen mothers in the group's programs had suffered abuse as children.

As the group learned more about sexual abuse and about the experiences of these young women, it began to look for a preventive approach.

An abusive childhood can mean an adult who is not sufficiently prepared to respond to the stresses of the world or, heartbreakingly, to the stresses of parenting. Here are the disturbing comments of two teenage mothers who were sexually abused as children:

"Still today I have problems with this terrible thing that has happened to me. I was abused when I was 5 and, believe me, I'm

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Keep Your Eye On

... ABCs and HIV.

Schools must prepare for the growing number of HIV-infected children who will be attending schools in coming years, according to an article posted on the electronic pages of *Pediatrics*. The article reports that the number of HIV-infected children was 12,000 in 1994, with nearly 40 percent of those children school-aged. In one study, the article reports, more than two-thirds of the children between ages 5 and 10 had not been told that they had HIV, and in more than half of the cases reviewed, the school had not been told of the child's infection. The authors suggest that health care professionals can assist the family in their decision to disclose their child's condition and can serve as an advocate in the educational system and offer guidance to school personnel on the medical issues that may arise for the HIV-infected child. *http://www.pediatrics.org*

... adults down on kids.

A national survey tells us that adults are really down on kids these days. Two-thirds of adults surveyed by the research firm Public Agenda said they think teenagers are "wild," "rude" and "irresponsible." Only 37 percent of the adults expressed confidence that the country will be improved by today's youth. The survey, "Kids These Days: What Americans Really Think About the Next Generation," found that adults believe the real crisis for teens is their values and morals. The survey is available for $12.50 from Public Agenda, 6 E. 39th St., New York, NY 10016. *School Board News, July 8*

... foreign language jump-start.

Foreign languages are most easily learned before middle school, but school programming tradition and cost stand in the way of change. Researchers say that a young child's ability to learn languages declines at about the age of puberty, just the time most schools introduce the new language to middle schoolers, who are more self-conscious and uncomfortable with trying new sounds. *School Board News, July 8*

... childhood OCD.

Researchers are recruiting patients ages 8 to 17 for a study to test the effectiveness of the selective serotonin reuptake inhibitor paroxetine (Paxil) to treat childhood obsessive-compulsive disorder (OCD) at the University of Texas Southwestern Medical Center at Dallas. For information on the 16-week trial, call (214) 640-5916.

... inhalant abuse.

A national campaign has been launched to educate children on the dangers of inhalant abuse, which, according to the Substance Abuse and Mental Health Services Administration, affects nearly half a million adolescents. Glue, lighter fluid, propane, felt-tip markers, cooking spray and nail polish remover are among the common inhalants used by children as young as 8 or 9. A new brochure available from the American Academy of Pediatrics helps parents understand the problem and educate their children about the dangers of sniffing these products. Copies are available from the American Academy of Pediatrics, Dept. C-Inhalant Abuse, PO Box 927, Elk Grove Village, IL 60009-0927. Send a business-size, self-addressed, stamped envelope.

... girl or boy next door.

The latest trend in drug abuse in this country is the alarming rise in heroin use that has tripled among preteens since 1991, according to the National Institute on Drug Abuse (NIDA). Today's users are likely to be suburban kids next door. NIDA is sponsoring a national conference on "Heroin Use and Addiction: Prevention, Treatment and Research" Sept. 29-30 in Washington, DC. For information, call (301) 468-6001.

What's New in Research

How effective is IV clomipramine for depression?

Major depressive disorder in adolescents often is treatment-resistant. In a recent study, investigators gave a single intravenous (IV) dose of 200 mg clomipramine (Anafranil) to eight adolescents and compared the results with eight patients given saline placebo. All patients had major depression, but were nonsuicidal. The mean age was 16.2 years.

Patients receiving clomipramine had significant decreases in Hamilton Depression Rating Scale scores from baseline at six days, but not at 36 hours. There also was a decrease from baseline in Clinical Global Impression severity at six days, but not at 36 hours, in treated patients. Seven treated patients had drops of 50 percent or more from baseline in Hamilton depression scores compared to three patients receiving placebo.

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The authors hypothesize that giving a single dose of IV clomipramine may be more effective than gradually administering it over a week to 10 days because of its rapid enhancement of serotonergic transmission.

"Pulse intravenous clomipramine for depressed adolescents: Double-blind, controlled trial," F.R. Sallee, N.S. Vrindavanam, D. Deas-Nesmith, et al., *American Journal of Psychiatry* 154:668-673, 1997. For reprints, contact Floyd R. Sallee, MD, PhD, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Institute of Psychiatry, Room PH 246, 171 Ashley Ave., Charleston, SC 29403.

Rural students at equal risk for substance abuse

Students living in the city or the country are equally at risk for alcohol and drug abuse, according to a recent study comparing high school seniors from 1976 through 1992. The study evaluated use of alcohol, cigarettes, marijuana, cocaine, LSD and inhalants; binge drinking; smoking (a pack or more a day); and daily alcohol and marijuana use. The study showed that overall substance abuse declined during the study period. However, in 1976, most substances were more prevalent among urban students, while by 1992, urban and rural students were similar. Rural students showed a higher prevalence of excessive use of alcohol and cigarettes. Trends were similar, regardless of sex. The study points out the need to address this pattern through alterations in health education programs in the nation's rural areas, according to the authors.

"Alcohol, tobacco and other drug use among rural/small town and urban youth: A secondary analysis of the "Monitoring the Future" data set," Christine E. Cronk, DSc, and Paul D. Sarvela, PhD, *American Journal of Public Health* (5)87:760-764, 1997. For reprints, write to Dr. Sarvela, Center for Rural Health and Social Service Development, Southern Illinois University at Carbondale, Carbondale, IL 62901.

Buying cigarettes is easy for some groups of kids

Snuffing out cigarette advertising may be only one way of reducing tobacco use among American teens, according to a recent study that suggests that age, racial/ethnic group and gender also play a role in minors' access to tobacco.

In the study, 36 minors tried to buy cigarettes once in each of 72 stores. Equal numbers of white, black and Latino boys and girls, ages 10, 14 and 16, made the purchases in white, black and Latino neighborhoods. Researchers found that store clerks were more likely to sell cigarettes to older children. Latino children were able to purchase more than whites, and older black children more than any other group. Male clerks were more likely to sell tobacco to minors than were female clerks. The study suggests that retailers may need to address sociocultural issues in reducing minors' access to cigarettes.

"An experimental analysis of sociocultural variables in sales of cigarettes to minors," Elizabeth A. Klonoff, PhD, et al. *American Journal of Public Health* (5)87:823-826, 1997. For reprints, write to Dr. Klonoff, Behavioral Health Institute, California State University, San Bernardino, CA 92407.

Study supports spectrum theory in eating disorders

A recently published longitudinal study on eating disorders in adolescents appears to disagree with DSM-IV classification of the disorders. The researchers found that contrary to DSM-IV criteria, the 55 patients did not cluster on the basis of anorectic symptoms. Bulimic symptoms were more dominant. They also found that core symptomatology (preoccupation with food, disturbed body perception and inadequate sexual behavior) do not differ between patients either at the time of referral or follow-up.

Relying on Morgan-Russell subscales, clustering was measured four times over the course of illness. Findings support the spectrum hypothesis of the eating disorders, which considers them as one syndrome with different manifestations.

"Empirically-based subgrouping of eating disorders in adolescents: A longitudinal perspective," T. Vanderham et al., *British Journal of Psychiatry*, 170(4):363-368, 1997. For reprints, contact Prof. H. van Engeland, Utrecht University Hospital, Department of Child and Adolescent Psychiatry, POB 85500, NL-3508 Ag Utrecht, The Netherlands.

Housing, helplessness affect ethnic birth outcomes

If a mother lives in public housing and believes chance determines her health status, it is likely her baby will have a lower birth weight than the baby of a mother with a stable residence and a more positive outlook, according to a recent study. The study sought to expand the search for risk factors associated with low birth weight and find explanations for ethnic group disparities in birth outcomes, among 1,150 pregnant women at prenatal clinics between 1987 and 1989. The women represented six groups: African-American, Chinese, Dominican, Puerto Rican, Mexican and white. Researchers found that material hardship, social adversity, racial discrimination, physical abuse, anxiety and depression were not associated with birth weight. The negative role of impoverished living, the mother's feelings of helplessness and the positive role of a stable social support contributed to low birth weight outcome and suggest new areas of research for its causes among ethnic groups.

"Ethnic differences in birth weight: the role of lifestyle and other factors," Patricia H. Shiono, PhD, et al., *American Journal of Public Health* (5)87:787-793, 1997. For reprints, write to Dr. Shiono, Center for the Future of Children, David and Lucille Packard Foundation, 300 Second St., Suite 102, Los Altos, CA 94002.

Resources

Courtroom model helps kids deal with real-life testimony

A new tool for helping children deal with the trauma of being called to testify in a courtroom is available from Kid's Kourt Inc., which has designed a miniature model complete with judge's bench, jury box, witness stand, counsel tables and dolls representing the lawyers, judge, witness and defendant.

Devised and patented by the Kenosha Victim/Witness Program Coordinator, lawyers, therapists and child advocates developed the model to educate children about the criminal justice system and help lessen the trauma of testifying. It is designed for use by lawyers and non-lawyers, including therapists, to build communication and trust between adult and child.

A number of books are also available. *Getting Ready for Court: A Book for Children, Volume 1,* helps prepare children who may be witnesses in a criminal proceeding; *Volume 2* addresses the needs of children going to civil court. Both books are in a workbook format and have been reviewed for neutrality and developmental appropriateness for elementary-school children. Another book, *Finding Your Way: What Happens When You Tell About Abuse,* written for 9- to 18-year-olds, discusses what happens when a child makes a disclosure. It is intended as an adjunct to advocacy, therapeutic or educational services.

For more information, contact Kid's Kourt, 7949 47th Court, Kenosha, WI 53142-2046, or call (800) 694-4038.

Get free issue on information systems

Whether you're drowning in data or just starting to measure client outcomes, you probably need to consider acquiring a management information system (MIS). The August issue of Behavioral Health OUTCOMES has a feature article on justifying MIS capacity and buying a system; the issue includes a four-page pullout supplement to help you get started. For a **free** *copy of the issue, call Barbara Deekle at Manisses customer service, at (800) 333-7771.*

Signs of sexual abuse in young children

There is no formula that will tell you for sure if your child is being sexually abused. Signals in children can be physical, but danger signs are usually revealed through a child's behavior. Even when children are not being abused themselves, these clues may appear in a child whose brother or sister is being abused.

The signals listed here are meant to give you an idea of what to look for. You should consider these signals in combination with everything else that is going on in your child's life. These signs could be clues to lots of different things. They may be the result of a physical or mental illness, or stress, such as a move to a new city or school. They may also occur when the child is being mistreated emotionally or physically.

Remember, children have many different reactions to the world around them. Many children who have never been sexually abused will behave in some of these ways. Parents and other adults have to figure out what children are communicating through their behavior.

You can directly ask a child if she or he has been touched, but even if the answer is no, pay attention to the way she or he answers: A strong overreaction or denial may be a sign of sexual abuse. Other children may say that something is hurting or bothering them, but are unable to be specific.

Signals that warn you that your child is in danger can be mostly based on intuition. You may feel that something is wrong. If you think about the feelings you are having, or talk to someone about them, you may be able to figure out what is wrong and what to do in order to feel more comfortable.

Physical signals

- Torn, stained or bloody underclothing
- Bruises or bleeding in the genital area, thighs, anus, mouth, chest
- Difficulty walking or sitting, limping
- Unusual vaginal discharge
- Recurrent urinary tract infections
- Lax rectal tone (obvious change in appearance of the anus)
- Sexually transmitted disease, detected through a blood test by a doctor
- Pain in the genital area
- Stomachache, vomiting
- Overeating
- Headache
- Itching of genitals or anus, unusual or offensive odors
- Rashes
- Allergies

Behavioral signals

- Extreme irritability for no reason, difficult to comfort
- Change in eating habits
- Change in sleeping habits, fear of sleeping, unusual fear of beds, nightmares, sleepwalking
- Gagging on food
- Self-destructive behavior
- Compulsive masturbation
- Change in level of activity (more or less)
- Reluctant to go to certain places or be with a certain person
- Not wanting to be left alone
- Too eager to please, change in behavior
- Sexual knowledge or talk about sex that seems beyond their age
- Regression such as thumb-sucking, bed-wetting, acting like an infant

Continued on next page

***Behavioral signals**, continued*

- Sex play with peers, toys or themselves that exceeds the level of information you think they should know
- Fear of adults
- Fear of being touched
- New or unsual fears
- Wearing too many clothes
- Sadness, anger, unhappiness, solitude, negativity, nervousness
- Destructiveness, abusive behavior toward others
- Arguing and fighting, not getting along with others, including parents
- Not being liked by other children or adults
- Fear of parents leaving, or indifference to parents leaving
- Fear of showers, washrooms
- Sudden self-consciousness about genitals
- Fear of dental exams
- Sudden interest in others' genitals, sexual acts, sexual terms
- Low concentration level, daydreaming
- Refusing to talk
- Secrecy, lying
- "Taking care of an adult," combing their hair, bringing drinks, etc.
- Very demanding, expects favors
- Bizarre or scary drawings
- Wetting or soiling pants, after having been successfully toilet trained
- Refusing to take off underwear
- Retreating to a fantasy world

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The Brown University Child and Adolescent Behavior Letter

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

Recommended Reading

Comparisons in Human Development: Understanding Time and Context — *J. Tudge, M.J. Shanahan and J. Valsiner, Eds., Cambridge Univ. Press, NY, NY, 368 pages, $49.95 (hardcover); (800) 872-7423.*

The contributors come from many disciplines and nations, but share a view: that developmental research must be concerned with processes that operate through time and are regulated by biological, social and cultural contexts. Besides contributions of the editors, the authors include Lucien Winegar, Gilbert Gottlieb, Hideo Kajima, James Youniss and Jeannette Lawrence.

Cults in our Midst: The Hidden Menace in our Everyday Lives — *Margaret Thaler Singer (Foreword by Robert Jay Lifton), Jossey-Bass, 380 pages, $25.95 (hardcover); (415) 433-1767.*

A leading authority on cults, Singer teams here with a former cult member to say that during periods of traumatic life change people are especially vulnerable to masters of manipulation.

Adolescence in Context: The Interplay of Family, School, Peers, and Work in Adjustment — *R.K. Silbereisen and E. Todt, Eds., Springer-Verlag, NY, NY, 430 pages, $95.95 (hardcover); (800) 777-4643.*

A scholarly, data-rich volume with contributions by Anne Petersen, Shirley Feldman, Nancy Galambos, Uwe Engel, Sheppard Kellam and David Farrington, with such diverse coverage as aggression in the classroom, the recent influences of two-earner family situations, race and family contexts and lifestyles.

Infant care

from page 1

that described above, requires low ratios of adults to children, small group sizes and continuity of care by well-trained teachers and caregivers. Recent studies confirm just how important these factors are to developmental outcome. Infants and toddlers who were in high-quality care were found to be more competent — socially and cognitively. Children with relatively unresponsive mothers and in low-quality care were found to be even less well-attached to their mothers, creating a "dual risk."

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Some of these same studies confirm the suspicion that infant and toddler care is shockingly low in quality, whether in centers or in the homes of others (both relatives and non-relatives). Quality is significantly lower than that for preschool care. Yet many states have regulations that do not begin to meet the needs for quality for this youngest age group.

Since millions of infants and toddlers are in child care in the United States today, many for more hours than they are with their immediate families, millions of infants and toddlers are at developmental risk.

Addressing the crisis

Our nation's social policy, such as it is, has often been at cross-purposes concerning care for infants and toddlers: (1) infant care may be dangerous, but (2) don't make it possible for most parents to stay home in the earliest months of life, but (3) get children into any kind of care so their mothers can get off welfare, but (4) get children into early intervention programs to improve their developmental outcome. In fact, the United States is far behind most industrialized countries in developing a coherent vision and policy about the care and education of its youngest children.

Policy is slowly moving in other areas affecting infants and toddlers.

Prenatal care for all poor and near-poor pregnant women is now covered by Medicaid. So is their nutrition, by the Special Supplemental Nutrition Program for Women, Infants and Children — but only until the annual federal appropriation is exhausted.

Published and circulated warnings about the effects of cigarettes and alcohol on the growing fetus are now required.

More good programs for early intervention, education and care are springing up, most prominently Early Head Start, Even Start and programs for children with handicapping conditions.

The Child Care Food Program, administered by the Department of Agriculture, provides food allowances for children not only in child care centers but in family child care homes, if their providers accept at least minimal training in nutrition and are connected with a non-profit center.

The Child Care and Development Block grant served 734,000 children in 1993, with a substantial "set-aside" for states to use to improve quality as well as the quantity of child care available. The 1996 welfare reform bill has substantially increased funding to states for child care, to allow welfare mothers to take paid employment while maintaining the old slots for low-income families.

The newly created Child Care Bureau within the U.S. Department of Health and Human Services is finally giving visibility to child care issues at the federal level. It is also able to provide a more integrated approach to the implementation of the various funding streams for child care and to technical assistance to states trying to improve their care.

The Bureau seems well aware of the particular problem of infant and toddler child care. Associate Commissioner Joan Lombardi, writing in the Department of Health and Human Services Child Care Bulletin, says, "We ask all of you to renew your commitment to improving the quality of care for infants and toddlers by:

- Expanding training and supports for infant care providers in your state and community.
- Stepping up efforts to ensure healthy and safe child-care environments through connections with the health community.
- Promoting positive relationships between parents and providers in their mutual efforts to care for very young children.
- Ensuring that parents have the information and resources they need to choose quality care."

Yet urging states to improve their regulation and monitoring of infant/toddler child care is not on the list.

Similarly, reimbursed parental leave at childbirth is nowhere on the national agenda. The Family and Medical Leave Act requires only unpaid leave and then only for companies that have more than 50 employees. Now that the most politically active, financially comfortable parents have been satisfied, further action to match what more than 100 other nations — including all other industrialized nations — provide seems remote. This is particularly distressing, since substantial paid leave at childbirth would not only give infants and their families a better start but it would greatly alleviate the crowding of infants into low-quality care.

With a system left so much to state control, and with budget concerns outweighing all other considerations in the minds of many federal and state policy-makers, it will be hard to summon the political will to make significant change.

Since so many young lives are affected, it is important to show policy-makers why and exactly how these issues matter. ■

Parents, and thus their children, can benefit a lot from feeling that teachers and caregivers are on their "team," helping them foster their children's development.

Eleanor Stokes Szanton is a lecturer at the Johns Hopkins School of Hygiene and Public Health.

Heart to Heart

from page 1

17 years old today and I still carry the memory, hurt and guilt with me."

"I was so scared that I used to sleep in my clothes every night. Sometimes I still do since I'm used to it."

As several participants in this program for teenage parents began to disclose such stories, professionals began to ask significant questions:

How extensive is the experience of child sexual abuse? Is there a link between childhood sexual abuse and childbearing in the teen years? How can we protect today's children from sexual abuse?

Abused children become teen parents

Child sexual abuse is a substantial national problem. A nationwide assessment by the National Committee to Prevent Child Abuse found 1 million substantiated child abuse cases in 1993. Fifteen percent of these, approximately 150,000 cases, involved sexual abuse. Responding to 12,314 reports of child sexual abuse in fiscal year 1993, investigators from the Illinois Department of Children and Family Services found credible evidence of abuse in 5,277 cases. In 4,167 of those cases the victim was female. In 3,929 cases the perpetrator was male. More than one-half of sexually abused Illinois children in 1993 were younger than 10 years of age. One-quarter were younger than six years (IDCFS 1994).

Research findings on the extent of child sexual abuse vary, in part because different definitions associated with context, age and episode are used. But all research indicates substantial numbers of people are abused as children: About 12 percent of men and 17 percent of women were sexually touched by adults before reaching the age of 13 years.

There seems to be a link between the experiencing of childhood sexual abuse and childbearing in adolescence. A majority of adolescent mothers in two surveys reported that they had been sexually abused as children.

Breaking the pattern

Can abuse be prevented? Yes, teaching adolescent mothers how to protect their children from sexual abuse seems to be helping. We must also educate the community in which the young mother and children live. This helps create a caring network of involved adults aware of and concerned about sexual abuse.

The primary goals of the Heart to Heart program are to strengthen adolescent parents' ability to protect themselves and their children from sexual abuse by:

- Increasing parents' knowledge of child development, and the ways in which sexual abuse can interfere with normal development.
- Promoting positive parenting skills
- Helping teen parents draw on local community resources for continued support and information relating to sexual abuse and its prevention.

Heart to Heart's success is augmented by innovative components that enable participants to share their stories, build support networks and draw on community resources. Several of these components are summarized below:

✓ **Journal writing.** By writing down their thoughts and observations, participants are able to chronicle their own learning and growth. Also, journal writing provides a vehicle for teens to express openly, often for the first time, their feelings about their own childhood experiences, and how these experiences color their adult lives.

✓ **Heartmates.** Each participant identifies trusted relatives and/or friends — called Heartmates — who pledge to support the teen parent and children following the completion of the Heart to Heart program. This helps to ensure that the learning and support that take place during the program are ongoing. If parents cannot identify a suitable Heartmate, a community volunteer or other mentor is found for them.

✓ **Community project.** At each program site, participants select, design and help to implement a project to enhance the community's knowledge of and responsiveness to child sexual abuse. Projects may be geared toward preventing sexual abuse, promoting increased reporting of abuse or helping to destigmatize abuse for those who have been victimized. Bringing these projects to fruition is an empowering experience for teen parents, enhancing their sense of self-efficacy and self-confidence.

Program techniques

Heart to Heart includes 12 group sessions, each of which is two to three hours long. In these sessions parents learn:

- Why it is important for the parent to be their children's primary sex educator.
- How to teach children the difference between a harmful secret and an appropriate confidence.
- How to select child-care providers.
- How to take positive actions to protect oneself and one's children.
- Why it is vital that parents believe children who tell of sexual abuse.
- How to recognize the early indicators of sexual abuse in young children.
- What to do if they suspect that their children are being abused.

The sessions are facilitated by trained volunteers — often former teen parents themselves — who teach under the close supervision of social workers. The volunteer facilitators model appropriate behavior and reinforce the positive parenting skills exhibited by participants. Heart to Heart also teaches parents that, if they were themselves abused in childhood, this can influence their lives and affect their parenting.

Through knowledge and skill-building, Heart to Heart promotes healthy parent/child relationships and encourages participants to take greater control of their lives. ■

Harriet Meyer is executive director of The Ounce of Prevention Fund, which designed and implemented the first Heart to Heart curriculum in 1987. For more information, contact Meyer at The Ounce of Prevention Fund, 122 South Michigan Ave., Suite 2050, Chicago, IL 60603.

Commentary

Whither the children?

Some of the world's children live in conditions that are quite unbelievable. My wife and I have just returned from a two-week trip to Brazil. We saw children of poverty and the terrible consequences of poverty — morbid standards of personal hygiene and medical care, lack of education and absence of hope and happiness.

We did not encounter serious predatory behavior from these young people, but we heard stories of attacks, by children on adults, and retaliation by adults.

Along with memories of naturally beautiful terrain and awesome artistic and engineering accomplishments, we have indelible impressions of what society reaps from systematic neglect of children.

In Rio de Janeiro there is an amazingly large Christ monument on top of the largest hill. It can be seen from almost any place in Rio. One gets there on a very steep tram, continuing on many stairs to reach the monument. The entire city then can be seen, with the surrounding ocean, and the bays and yachts.

We also rode a 75-person gondola from the base of a mountain to the top of the next, then another from that peak to the top of another. These excursions are thrilling, and all of this combined with the wonderful Brazilian music was exhilarating. How lofty are the aspirations and accomplishments of humankind.

But then one must get back to earth, where people live, and that is where the problem is. Humans have in 100 years invented and refined automobiles and airplanes, the telephone, television and computers. But in contrast with the enormous advances made in electronic communications and in public health and medical research, we have not made significant scientific and public-policy inroads on the two most important problems that civilized people have — poverty and warfare. Both are arguably bigger life-burdens of the young than of the adults who cause them.

In Brazil, a country with marvelous music and literature, and so many beautiful people of all shades, one finds many poverty-stricken youngsters. They pick pockets and endanger others by grabbing jewelry from the wrists or ears of people who ignore warnings provided to all tourists. These youngsters, called "sewer children" by the Brazilians, are kids without families or homes. Many do live underground and fend for themselves, often with no roof but a cardboard carton. They have been surviving this way from such an early age that they cannot remember having had parents.

Brazil is not alone, of course. Colombia has been living with its "gamino problem" for years. One reads this month, too, of children of Phnom Penh who have known life only as soldiers. Most have killed other teenagers. It is their way; it is their life.

These problems require change of behavior — the behavior of responsible adults and societies. I doubt if genius equal to that of Brazil's monument builders and tram engineers is required to make significant advances in the humane care of children. The problem is of nearly unimaginable proportions, but has pessimism stifled the physicists, chemists and biologists in their search for solutions to ineffably difficult problems in *their* domains?

Economics and parenthood, like warfare, are essentially behavioral matters. Poverty and the abandonment of children are about kids growing up without significant attachments to others, with no opportunity to acquire trust in others. These are psychological matters about which we know something. We also know about irresponsible parentage and parenting. Part of the problem is people having children (a behavioral process) that they frequently don't want.

"Sewer children" are discarded children. We must ask why society hasn't addressed this effectively. Is it too much to ask: "Can't somebody do something about this?"

For many people who subscribe to a democratic philosophy and for whom self-determination and freedom are valued states of existence, behavioral engineering is anathema. Yet serious social problems must be addressed with behavioral solutions. Incentive-controlled behavior must be challenged with the introduction of alternative incentives. Humane pathways to adulthood must be found for "sewer children."

Ironically, we are more inclined to find deplorable care of children in other countries, and to overlook terrible conditions to which children closer to us are subjected. The plight of children is worldwide.

We must look closely at the social and behavioral conditions that produce human misery, especially the inhumane conditions in which many of the world's children live. Poor social engineering, much of it in otherwise wealthy cities of the world in the wake of rapid industrial development, is surely one of the root causes of the misery in which so many children live today.

The poor children of the world cannot or are unlikely to unite. Responsible adults of the world must speak and act for them. ■

Lewis P. Lipsitt

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work

Special Report

Interracial children, parents educators face unique challenges

By Ferdinand Jones, PhD and Joanne Jones Rizzi

Interracial children face substantial obstacles imposed by society in developing competent senses of themselves, whether in biological or adoptive homes.

What guidance can behavioral science provide parents and educators of these children? Child-rearing questions are always hard to separate into discretely researchable units, and this particular set of developmental issues has only recently become numerically critical. Furthermore, the methods in which behavioral research has the most confidence — random sampling, the use of control groups and provable hypotheses — have been difficult to apply to the study of interracial children.[1]

> ***It should be emphasized... that after all is considered, it is culture and not race that is the significant arena in which much of the interracial individual's dilemmas reside.***

Of course, the issues have been significant among some segments of the American population for many years, but changes in attitudes and socio cultural dynamics in the last few decades have caused more people across a broader spectrum of the society to pose questions about interracial children's development.

Their questions span complex theoretical issues that are not easily separated from other dimensions. These may be political, or they may stem from social class, or they may concern geographic, generational, adoption and physical appearance variables. Our article will distill prominent re-

(turn to 2)

PS 026390

Special Report August 1997

Dear Reader,

More than 2 million young Americans can trace a mixed heritage and will encounter circumstances specific to their unique identity. The foremost question of adolescence — "Who am I?" — takes on complex dimensions as a new generation of multiracial young people grows up. In a society that is in so many ways racially divided, what does it mean to embody a blend of several worlds?

On these pages, members of two interracial families offer good ideas on how we can prepare these children to address the obstacles they may face.

— Lewis P. Lipsitt, PhD
Editor

Commentary

Mothering across the color line

By Maureen T. Reddy, PhD

My husband, Doug, is black and I am white. Our children — 13-year-old Brendan and 5-year-old Siobhan — say they are black, biracial, Irish-American and/or African-American, depending on who asks them and when.

Context is everything. Which is not to say that their identities change according to context, but simply that what they say about those identities changes.

I have noticed that my children tend to be especially adamant about the elements of their identities that they suspect people — including their own parents — may ignore or deliberately try to deny in particular situations.

Growing up white, I never had much consciousness of race in relation to myself. While I was certainly aware of racism by the time I was a young teen, I did not think of race as a shaper of my own life, and was not aware of the innumerable benefits whiteness conferred on me until I became involved with Doug and began to lose some of those privileges, at least sometimes and in some places. Even then, I continued to have only a partial consciousness of race.

One of the great, and of course

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Self-identity

from page 1

search findings and commentary and suggest perspectives parents and educators may find applicable to their concerns

> One biracial adult reports: "*What is it with people? Is it me? People I don't know, strangers come up to me and ask, 'What are you? Are you Indian? Are you from Africa?' When I'm generous, I'll talk to them, but talking to strangers about who I am frightens me, makes me feel too vulnerable, I guess ... I want to be left alone. I don't want to talk to strangers about who I am. I don't want the responsibility to satisfy some need they have to categorize, to make me be something they are comfortable with, something they can understand. But over the years it has made me unsettled.*"

The statistics

The number of interracial children in the United States has been rising steadily. According to the Bureau of the Census, as reported in *Time* magazine , May, 5 1997, there are now more than two million multiracial children. The increases mainly reflect the rise in the number of interracial marriages which, according to *Time* magazine, Fall 1993, have increased from 310,000 to 1.1 million over the last two decades. Developments such as accelerated urbanization, greater social mobility and the blurring of ethnic residential and institutional boundaries have resulted in an attitudinal shift in support of interracial marriages. The placement of numbers of children of color in white adoptive families is an extended dimension of this subject.

Despite what these developments might optimistically suggest about progress toward pluralism in American society, a variety of historical and psychological conditions determine that feelings about racial differences remain pivotal aspects of North American consciousness.

"One drop" rule

Not many years ago, North Americans assigned the offspring of racially diverse parents to the category of the non-white parent. Anyone with any identifiable amount of "the other" ancestry was legally non-white and subject to numerous derogatory labels. The "one drop" rule was especially ironic in the case of African-Americans because, as a group, they have not been genetically pure since the centuries-long and ubiquitous sexual exploitation of female slaves by their masters. Up until the last few decades interracial couples were essentially required to reside in non-white areas or in the small number of mixed communities; and their children, labeled black, or a sub-category of Asian, experienced the same limited social mobility as their African-American or Asian-American peers.

Interracial individuals may feel unsettled, being simultaneously in and out of two or more cultures all to which they feel some affinity, while resisting the exotic ones into which others would place them.

Psychologist Maria P.P. Root, PhD, notes the intransigent realities that are important for understanding the social forces that affect all individuals of color in the United States:

- The positive melting pot imagery is only relevant to white ethnic groups.
- White is persistently considered inherently superior to non-white.
- There is a hierarchy of racial/cultural groups based on their similarity to middle-class white social structure and values.[2]

Still, there seems to be a gradual softening of attitudes toward consensual interracial closeness, perhaps as a consequence or symptom of the end of legal discrimination and the repeal of anti-miscegenation laws.

Defining racial identity

This is the socio-historical context in which groups of mainly urban middle-class interracial parents are organizing to promote their own definitions of their children's racial identity. They prefer the term "multiracial" or "biracial" rather than what seems to them to be the inaccurate and arbitrary classifications of the past.

Some African-Americans view the multiracial movement to be a rejection of the African heritage they themselves are vigorously embracing. They believe that self-declared biracial individuals are opportunistically distancing themselves from their non-white identity because they prefer not to be associated with an unceasingly disparaged group.

A paradox in African-American communities, incidentally, is the evolution of efforts to refine the meaning of the African-American identity. Psychologists working in this area describe the complexity of the very idea of self-concept. And they indicate that when the dimension of race is added it becomes an even more elusive construct.[3]

The quest for self

No matter its complexities, developing children need to know who they are. They get this knowledge from their parents, or other primary caregivers, and extended family and community members. Jacobs describes four stages of racial identity formation of multiracial children that includes the critical variable of skin color. The child first masters the constancy of color; then internalizes an interracial or biracial label; deals with ambivalence about racial identity; and, finally, reconciles the perceptual distortions that account for and allow the child's own and the family's mixed racial identifications.[4]

Interracial children, along with other children of color, must incorporate the reality of their vulnerability to hostile treatment by majority group members. Boykin and Toms cite four coping patterns that develop out of ethnic minority children's individual personalities and circumstances that enable them to effectively respond to racist occurrences:

1. active/passive;
2. system engagement/system disengagement,
3. system maintenance/system change; and
4. system blame/person blame,[5]

The implication of this analysis for caregivers is that children of color need to be prepared for the inevitable mistreatment they will receive from some intentionally hostile or insensitive white Americans. In the cases of multiracial children, these may even be members of their own extended families.

The implication of this analysis for caregivers is that children of color need to be prepared for the inevitable mistreatment they will receive from some intentionally hostile or insensitive white Americans. In the cases of multiracial children, these may even be members of their own extended families.

Marginalization defined

The task for interracial children's parents and teachers may also include the complications that stem from the growing child's marginalization from whites and other minorities. Brown defines a marginal person as, "one whose socialization has not been such to prepare him to play the role assigned him in the social sphere. There are forces preventing him from making his reference group a membership group."[6]

Interracial individuals may feel unsettled, simultaneously in and out of two or more cultures, all to which they feel some affinity, while resisting the exotic ones into which others would place them.

Here is where appearance is sometimes a convenient, but only partially satisfactory, refuge for some. If they look white enough, and they are not in the company of a darker relative, they get temporary relief from the stares and questions. These moments can become a way of life for those who choose to internally identify with their white parent and the power that accompanies that identity.

A similar process, minus the component of white power, may attract the mixed-race individual who looks black.

Marginalization is not inevitable, in our view, however. If the person identifies as African-American or is integrated into an Asian-American community, or decides she or he is white — and these choices are indeed made by many individuals — she or he may not actually feel rejected isolation. Everyone is a complicated combination of individual traits and characteristics. As the developing child increasingly acquires the cognitive capacity to accommodate life's intricacies, she or he can also comprehend a complex self-identity.

Many interracial children, however, do report feeling distressingly apart from both sides of their mixed heritage. This condition can present formidable challenges. Some report feeling a mixture of confusion, loneliness and annoyance at times as they are growing up, and even later as adults in a society that seems so preoccupied with race.

Geography, too, plays a critical part in the multiracial person's adjustment. Growing up in areas where there are more than a few similar families minimizes feelings of isolation and alienation. It provides a range of role models. It reinforces the pluralistic values multicultural families usually espouse. It girds the self-confidence of developing children, especially during adolescence, when dating rituals and the prejudices that emerge often bear disproportionate weight in the young person's establishment of a sense of self-worth.

The professional literature reaches circular conclusions about the comparative mental health of interracial individuals. These individuals can potentially be drawn into the dominant culture's standards and values at the expense of their own uniqueness, or they can get stuck in the stance of challenging and rejecting these same standards.

Also they may have insufficient role models, leaving them to discover their own paths with all of the anxiety and loneliness this can entail.

Mental health implications

However, Gibbs, who studied a clinical sample of biracial college students, observed that though they individually reported formidable identity and social problems, as a whole they had no more identity and adjustment problems than did white or African-American adolescents.[7]

In another article Gibbs and Hines indicate that positive developmental outcomes among interracial youngsters is enhanced by supportive families, cohesive social networks and integrated schools and neighborhoods.[8]

Root reminds us that all intrapersonal and interpersonal conflicts are circular and transitory. "They re-emerge at different points in development with the chance for greater depth of resolution and understanding with each cycle," she says.

No one suggests there is only one acceptable route toward strong identity and self-esteem in interracial children or in any other children. However, Root, in the same discussion, synthesizes the broad and sometimes overlapping directions in which psychologically competent interracial development can proceed:

- Acceptance of the identity society assigns.
- Identification with both racial groups.
- Identification with a single racial group.
- Identification as a new racial group.[9]

The key point for psychologicall health seems to be that the individual makes a thoughtful, knowledgeable and active choice.

The adoption of children of color by white families may, ironically, suggest a child-rearing perspective for biologically multiracial families. Thoughtful adoptive parents assume they must teach the child who doesn't look like them, but who is no less a member of their family, about this discrepancy. In the best of such instances the children grow to have a strong sense of their native culture as well as the culture of their adoptive family.

But after all is considered, it is culture and not race that is the significant arena in which much of the interracial individual's dilemmas reside.

Like all Americans, these persons are steeped in the values and customs of the dominant white, middle-class North American culture. And like all Americans who do not fit this definition of "normal," a comfortable alternative identity has to be forged. For people of color this means integrating another cultural experience.

Caregivers of mixed-race children need not worry that white American culture will be shortchanged in their child's upbringing. No one, even if they wanted to, can avoid learning the precepts of mainstream American life. The task for people of color is to ensure that the other experience, both in its protective and expressive aspects, is learned.

Relatedly, the challenge parents and educators of all children face is to prepare their children for a world that is rapidly getting more fluid along every conceivable dimension. ■

Ferdinand Jones is emeritus professor of psychology at Brown University, and the retired director of psychological services. Joanne Jones-Rizzi, his daughter, is the director of the cultural program of The Children's Museum in Boston.

References

[1] Maria P.P. Root. "Back To The Drawing Board: Methodological Issues In Research On Multiracial People." in , *Racially Mixed People In America*, edited by M.P.P. Root, Sage, Thousand Oaks, CA, 1992.

[2] Maria P.P. Root,. "Resolving the "Other" Status: Identity Development of Biracial Individuals." in *Diversity And Complexity In Feminist Theory And Therapy*, edited by L. Brown & M.P.P. Root, Haworth, New York, 1990, page 187.

[3] Janet Helms, E.*d.* *Black and White Racial Identity: Theory, Research, and Practice*. Greenwood Press, Westport, CT, 1990

[4] J.H. Jacobs, "Identity Development in Biracial Children," in *Racially Mixed People In America*, edited by .M.P.P Root.

[5] A.W. Boykin & F.D. Toms, "Black Children's Socialization: A Conceptual Framework," in *Black Children: Social, Educational, And Parental Environments*, edited by H.P. McAdoo & J.L. McAdoo, Sage, Thousand Oaks, CA 1985, pages 33-52.

[6] P.M. Brown, "Biracial Identity and Social Marginality." *Child and Adolescent Social Work*, 7, 327, 1990.

[7] J.T. Gibbs, "Identity and Marginality: Issues in the Treatment of Biracial Adolescents." *American Journal Of Orthopsychiatry*, 57, pp. 265-278.

[8] J.T. Gibbs & A.M. Hines, "Negotiating Ethnic Identity: Issues for Black-White Biracial Adolescents," *Racially Mixed People In America*, edited by M.P.P Root, pages 223-238.

[9] Maria P.P. Root *"Resolving the 'Other' Status: Identity Development of Biracial Individuals,"* page 189.

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Drug abuse prevention: Programs that work

All around the country there are drug prevention programs that are working and that can be replicated. In cooperation with research scientists, the National Institute on Drug Abuse (NIDA) prepared a description of programs that are proving effective. Each has been developed as part of a research protocol and tested in a family, school or community setting. These programs are categorized by a new series of definitions, which describe the programs by the audience for which they are designed:

- ***Universal programs*** *reach the general population — such as all students in a school.*
- ***Selective programs*** *target groups at risk or subsets of the general population — such as children of drug users or poor school achievers.*
- ***Indicated programs*** *are designed for people who are already experimenting with drugs or who exhibit other risk-related behaviors.*

We publish this material as a useful resource and, hopefully, to serve as a catalyst for the development of other successful programs.

Project STAR

This is a universal drug abuse prevention program that reaches the entire community with a comprehensive school program, mass media efforts, a parent program, community organization and health policy change. The middle school-based component is a social influence curriculum that is incorporated in classroom instruction by trained teachers over a two-year timetable. Mass media are used to promote, reinforce and help maintain the project. Parents work with their children on Project STAR homework, learn family communication skills and get involved in community action.

The community organization component is the essential formal body that organizes and oversees all project-related activities. The health policy change component is implemented as a task of the community organization; the aim is to develop and implement policies that affect alcohol, tobacco and other drug laws, and other local policies, such as establishing and monitoring drug-free sites in the community.

Research on this project has shown positive long-term effects: In their senior year of high school students who began the program in junior high showed significantly less use of marijuana (approximately 30 percent less), cigarettes (about 25 percent less) and alcohol (about 20 percent less) than teens in schools that did not offer the program. The most important factor found to have affected drug use among the students was increased perceptions of their friends' intolerance of drug use.

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Life Skills Training Program

The Life Skills Training universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. The program consists of a three-year prevention curriculum intended for middle or junior high school students. It contains 15 periods during the first year, 10 booster sessions during the second, and five sessions during the third.

Three major content areas are covered by the Life Skills Training program:

- Drug resistance skills and information provide material that deals directly with the social factors promoting drug use. This content area includes material designed to increase awareness of social influences toward drug use, correct the misperception that everyone is using drugs and promote antidrug norms, teach prevention-related information about drug abuse, and teach drug resistance skills.
- Self-management skills help students increase independence, personal control and a sense of self-mastery. This includes teaching general problem-solving and decision-making skills, critical thinking skills for resisting peer and media influences, skills for increasing self-control and self-esteem (such as self-appraisal, goal setting, self-monitoring, self-reinforcement), and adaptive coping strategies for relieving stress and anxiety.
- General social skills enhance students' social competence, including how to communicate effectively, overcome shyness, meet new people and develop healthy friendships. These skills are taught through a combination of instruction, demonstration, feedback, reinforcement, behavioral rehearsal and extended practice through homework assignments.

The Life Skills Training program has been extensively studied over the past 16 years. Results indicate that this prevention approach can produce 59 to 75 percent lower levels (compared to a control group) of tobacco, alcohol and marijuana use. Booster sessions can help maintain program effects. Long-term follow-up data from a randomized field trial involving nearly 6,000 students from 56 schools found significantly lower smoking, alcohol and marijuana use six years after the

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initial baseline assessment. The prevalence of cigarette smoking, alcohol use and marijuana use for the students who received Life Skills Training program was 44 percent lower than for control students, and the weekly use of multiple drugs was 66 percent lower.

Although the early research with the Life Skills Training Program was conducted with white populations, several recent studies show that it is also effective with inner-city minority youth. It also has been found effective when implemented under different scheduling formats and with different levels of project staff involvement. Finally, evaluation studies indicate that this prevention program works whether the program providers are adults or peer leaders.

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Adolescent Alcohol Prevention Trial (AAPT)

AAPT is a universal classroom program designed for fifth-grade students, with booster sessions conducted in the seventh grade. It includes two primary strategies. Resistance skills training is designed to give children the social and behavioral skills they need to refuse explicit drug offers. Normative education is specifically designed to combat the influences of passive social pressures and social modeling effects. It focuses on correcting erroneous perceptions about the prevalence and acceptability of substance use and on establishing conservative norms.

In the research design, the students received either information about consequences of drug use only, resistance skills only, normative education only, or resistance skills training in combination with normative education. Results showed that the combination of resistance skills training and normative education prevented drug use; resistance skills training alone were not sufficient.

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Seattle Social Development Project

A universal program, the Seattle project is a school-based intervention for first through sixth graders that seeks to reduce shared childhood risks for delinquency and drug abuse by enhancing protective factors. The multicomponent intervention trains elementary school teachers to use active classroom management, interactive teaching strategies and cooperative learning in their classrooms.

As children progress from grades one through six, their parents are provided a training session called "How to Help Your Child Succeed in School," a family management skills training curriculum called "Catch 'Em Being Good," and the "Preparing for the Drug-Free Years" curriculum. The interventions are designed to enhance opportunities, skills and rewards for children's prosocial involvement in both school and family settings, thereby increasing their bonds to school and family and commitment to the norm of not using drugs.

Long-term results indicate positive outcomes for students who participated in the program: reductions in antisocial behavior, improved academic skills, greater commitment to school, reduced levels of alienation and better bonding to prosocial others, less misbehavior in school, and fewer incidents of drug use in school.

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Adolescents Training and Learning To Avoid Steroids

The ATLAS program is a multicomponent universal program for boys in high school athletics, designed to reduce risk factors for use of anabolic steroids and other drugs while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Coaches and teammates facilitate curriculum delivery with scripted manuals in small cooperative learning groups, taking advantage of an influential coaching staff and the team atmosphere where peers share common goals. The seven 45-minute classroom sessions and seven physical training periods involve role- playing, student-created campaigns and educational games. Instructional aids include pocket-sized food and exercise guides and easy-to-follow student workbooks. Parents are involved with parent-student homework and with the booklet "Family Guide to Sports Nutrition."

The program features learning about anabolic steroids and other drugs, skills to resist drug offers; team ethics and drug-free commitment; drug use norms, vulnerability to drug effects; debunking media images that promote substance abuse; parent, coach, and team intolerance of drug use; and goal-setting for sports nutrition and exercise. Weight-lifting instruction at the schools promotes safe training practices, reduces the influence of commercial gyms (where anabolic steroids and other drugs are more available) and highlights curriculum components.

Student athletes in the ATLAS program report better understanding of the effects of anabolic steroids and other drugs, greater belief in personal vulnerability to the adverse effects of anabolic steroids and more certainty that their parents and coaches are intolerant of drug use. In addition, improved drug refusal skills, less belief in steroid- promoting media images, more confidence in personal ability to build muscles and strength without steroids, greater self-esteem and less desire to use anabolic steroids were found among members of the intervention groups.

Importantly, these high school athletes continued to resist the temptation of anabolic steroids and maintained better nutrition and exercise behaviors one year after the intervention. The program contains four booster sessions for each subsequent year of high school.

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Project Family

Project Family is a series of interrelated investigations designed to: evaluate universal family and youth competency-training interventions to examine the process of positive change in families; test the factors influencing parent participation in family programs; and conduct statewide needs assessment surveys to determine family and community needs throughout Iowa. The prevention interventions evaluated through Project Family are Preparing for the Drug-Free Years (PDFY), developed at the University of Washington, and the Iowa Strengthening Families Program (ISFP), a revision of the University of Utah Strengthening Families program (next). The PDFY has five competency-training sessions for parents; one of these sessions is attended by adolescents and parents together. The ISFP has seven sessions, each attended jointly by youth and their parents. The project has also been adapted for Native American populations.

Comparisons of both interventions with control group families show positive effects on parents' child management practices (for example, standard-setting, monitoring, discipline) and on parent-child affective quality. In addition, a recent evaluation of ISFP youth outcomes at the one-year follow-up shows improved youth resistance to peer pressure toward alcohol use, reduced affiliation with antisocial peers, and reduced levels of problem behaviors. Importantly, intervention post-test outcome models demonstrate that positive parenting effects were significantly associated with reductions in children's problem behaviors. Study results are guiding efforts to evaluate whether adding a family intervention to a school intervention is better than use of a school intervention alone.

The second component of the research project studied the most effective ways of recruiting family participation. Findings highlight the importance of a number of practical recruitment and retention strategies, such as flexibility in intervention scheduling, minimizing initial time commitments, contracts from parents' peers and multiple incentives such as free food coupons, refreshments and child care. The statewide surveys assessed the prevalence of risk factors, protective factors and substance-related problems, which have been utilized for health planning purposes.

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Strengthening Families Program

Strengthening Families is a selective prevention, multicomponent, family-focused program that provides prevention programming for 6- to 10- year-old children of substance abusers. The program began as an effort to help substance-abusing parents improve their parenting skills and reduce their children's risk factors. The program has been culturally modified and found effective with African-American, Asian/Pacific Islander, and Hispanic families.

In each of the 14 weekly sessions, parents and children are trained separately in the first hour. During the second hour, parents and children come together in the family skills training portion. Afterward, the families share dinner and a film or other entertainment. Parent training improves parenting skills and reduces substance abuse by parents. Children's skills training decreases children's negative behaviors and increases their socially acceptable behaviors through work with a program therapist. Family skills training improves the family environment by involving both generations in learning and practicing their new behaviors.

This intervention approach has been evaluated in a variety of settings with several racial and ethnic groups. The primary outcomes of the program include reductions in family conflict, improvement in family communications and organization, and reductions in youth conduct disorders, aggressiveness and substance abuse.

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Focus on Families

A selective program for parents receiving methadone treatment and for their children. Focus on Families' primary goal is to reduce parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to manage their families better. The parent training consists of a five-hour family retreat and 32 parent training sessions of an hour and a half each. Children attend 12 of the sessions to practice developmentally appropriate skills with their parents.

Session topics include family goal-setting, relapse prevention, family communication, family management, creating family expectations about alcohol and other drugs, teaching children skills (such as problem solving and resisting drug offers), and helping children succeed in school. Booster sessions and case-management services also are provided. Early results indicate that parents' drug use is dramatically lower and parenting skills significantly better than are seen in control groups, but the program's effects on children have not yet been assessed.

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Reconnecting Youth Program

Reconnecting Youth is a school-based indicated prevention program that targets young people in ninth through 12th grade who show signs of poor school achievement and potential for dropping out. They also may show signs of multiple problem behaviors, such as substance abuse, depression and suicidal ideation. The program teaches skills to build resiliency with respect to risk factors and to moderate the early signs of substance abuse. To enter the program, students must have fewer than the average number of credits earned for their grade level, high absenteeism and a significant drop in grades. Or a youth may enter the program if he or she has a record of dropping out or has been referred as a significant dropout risk.

The program incorporates social support and life skills training including:

- Personal Growth Class, a semester-long, daily class designed to enhance self-esteem, decision making, personal control and interpersonal communication;
- Social Activities and School Bonding, to establish drug-free social activities and friendships, as well as improving a teenager's relationship to school;
- School System Crisis Response Plan, for addressing suicide prevention approaches.

Research shows that this program improves school performance; reduces drug involvement; decreases deviant peer bonding; increases self-esteem, personal control, school bonding and social support; and decreases depression, anger and aggression, hopelessness, stress and suicidal behaviors. Further analysis indicates that the support of Personal Growth Class teachers contributes to decreases in drug involvement and suicide risk behaviors.

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Adolescent Transition Program

The ATP is a school- based program that focuses on parenting practices and integrates the universal, selective, and indicated approaches for middle and junior high school interventions within a comprehensive framework.

The universal level of the ATP strategy, directed to the parents of all students in a school, establishes a family resource room. The goal, through collaboration with the school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use. A videotape "Parenting in the Teenage Years," helps parents identify observable risk factors and focuses on the use of effective and ineffective family management skills, including positive reinforcement, monitoring, limit setting and relationship skills to facilitate evaluation of levels and areas of risk.

The selective level of intervention, the "Family Check-Up," offers family assessment and professional support to identify those families at risk for problem behavior and substance use.

The indicated level, the "Parent Focus" curriculum, provides direct professional support to parents for making the changes indicated by the Family Check-Up. Services may include behavioral family therapy, parenting groups or case management services. Following this tiered strategy, a family in the indicated parenting intervention would have participated in a Family Check-Up and received information from the school's family resource room about risk factors for early substance use and parenting practices that reduce the risk of drug use for children.

This program is based on a series of intervention trials, which compromise the Parent Focus curriculum and other intervention strategies, including working with high-risk teens in groups (Teen Focus curriculum) and directed strategies involving videotapes and newsletters. The findings from these studies indicate that parent interventions are needed for youth at high risk to reduce escalation of drug use, and repeated booster sessions are needed throughout the period of risk. These interventions were especially important because it was found that youth at high risk should not be placed together in groups because it can worsen problem behaviors, including those related to school and drug use.

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Selected Resources

For more information on National Institute on Drug Abuse (NIDA) research:

Visit NIDA's home page on the World Wide Web at http://www.nida.nih.gov. To learn more about prevention research, click on the Division of Epidemiology and Prevention Research. For information on community-based data from the Community Epidemiology Work Group, click on CEWG. For PREVLINE information from the National Clearinghouse for Alcohol and Drug Information home page, go to http:/www.health.org.

For information on National Institute of Alcohol Abuse and Alcoholism (NIAAA) research:

Visit NIAAA's home page on the World Wide Web at http://www.niaaa.nih.gov. Full text of many NIAAA publication are available, as well as program announcements identifying research priorities and NIAAA's online bibliographic database, which contains approximately 100,000 records.

For NIDA publications and prevention materials:

National Clearinghouse for Alcohol and
Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
(800) 729-6686

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For more information

Online Resources

Interracial Voices

http://www.webcom.com/intvoice.html

A bimonthly electronic publication which advocates the universal recognition of mixed-race individuals as constituting a separate racial entity. The website includes articles about multiracial issues, texts of speeches, a point-counterpoint section, a campus happenings section, interviews with leading public figures, and reviews of recent books and articles.

International Interracial Association

http://icg.stwing.upenn.edu/%7Ekonrad/iia/new.html

The association is open to anyone who is interested in furthering racial unity through discussion and support of interracial individuals. The site includes a calender of worldwide events, a discussion forum, a what's new section, and links to an extensive collection of resources and success stories.

Project RACE

http://www.projectrace.mindspring.com/

"Reclassify All Children Equally," an acronym for Project Race is a national organization looking to get a multicultural classification for people of mixed-race heritage. Located on its home page are links to the latest news and federal information, as well as state legislature groups and a group history. A section with links to other websites dealing with multiracial issues.

Recommended Reading

RACIALLY MIXED PEOPLE IN AMERICA, Maria P.P. Root, PhD, (Ed.), Sage Publications, Thousand Oaks, CA, 1992, (805) 499-0721.

A comprehensive look at the social and psychological adjustment of multiracial people, including models for identity development, contemporary immigration and marriage patterns, and methodological issues involved in conducting research with mixed-race people, all in the context of America's multiracial past and present. Included in the book are selections written by professionals from a variety of fields, such as ethnohistory, psychology and sociology.

EVERYDAY ACTS AGAINST RACISM: RAISING CHILDREN IN A MULTIRACIAL WORLD, Maureen T. Reddy, PhD, (Ed.), Seal Press, Seattle 1996, (800) 754-0271.

Mothers and teachers look at the effects racism has on children and communities, while suggesting practical ways to end racial divisions. Drawing on diverse cultural perspectives as well as experiences in multiracial families, the contributors offer commentaries on racial intolerance and their experiences fighting it.

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Mothering

from page 1

dangerous, privileges of whiteness is precisely that lack of consciousness about race: Most white people do not have to think about race unless they choose to, and even then, seldom in relation to themselves. Becoming a mother of black children moved race permanently to my consciousness; through having responsibility for my children's development, I learned to see the world differently. Every decision, from minute to major — from choosing books to choosing day care — resonated with racial implications.

Pregnant with my first child while finishing my PhD dissertation 14 years ago, I did what most well-trained researchers would do: I went looking for information and expert opinion.

I wanted to read about how and when to prepare my child to fight racism, how to talk about race openly, how to help my child to have a strongly positive self-concept in the teeth of the racist dragon that is America.

I was shocked to discover how little of the type of information I most needed was available. Most child-care books completely ignored race, with the exception of the few aimed specifically at black families, which in turn ignored the possibility that a black child might have a white parent.

Although more attention has recently been given to children in interracial families, the scarcity of information continues to be a problem for interracial families, especially for white parents in such families.

My children's questions about and attitudes toward race have taught me to examine my own assumptions and to revise my views.

For instance, both Doug and I thought of Brendan as black and Irish, until at age 6 Brendan corrected us, saying he was "biracial."

> *Becoming a mother of black children moved race permanently into my consciousness; through having responsibility for my children's development, I learned to see the world differently. Every decision, from minute to major... resonated with racial implications.*

We were careful to leave the biracial possibility open with our daughter, but she seems to identify more as black, perhaps because she is following her brother's lead and that is how he currently identifies himself.

She told me last year about a dispute with a playmate who said Siobhan was not "really black, but kind of pale." Siobhan informed this child, "I am a black girl, just like you."

Describing the incident to me later, Siobhan added, "That kid is really confused, Mom! She thinks black is just one color."

Race is social and political, not biological. I am pleased that my children see blackness positively but also that they recognize both the political nature of race and its fundamental arbitrariness.

Influenced by a culture that sees interracial families as inherently problem-ridden, I anticipated, before actually having children, that my children would have identity difficulties. I was wrong.

Despite the scarcity of images of interracial families in the media and the widespread racism that virtually guarantees such images will continue to be rare, my children see their family as entirely ordinary.

One night in December, as we lay together on her bed in the dark toward the end of my daughter's lengthy going-to-bed ritual, Siobhan said in a musing tone, "You know, I always thought God was black."

Since we don't have a religion, I wasn't entirely sure what she meant by "God," so I replied, "Well, no one really knows if there is a God or what God might look like, so God could be black."

Siobhan sat up. "But what about that white-looking God on the Christmas card we got today?" Before I could answer, she exclaimed, "Oh, I know: God's mother might be white." ■

Maureen Reddy is professor of English at Rhode Island College, where she also directs the women's studies program. The author of Crossing the Color Line: Race, Parenting, and Culture (Rutgers University Press), Dr. Reddy is currently working on a book on race in popular fiction and film.

- Between 1968 and 1989, children born to parents of different races increased from 1% of total births to 3.4%, according to the Population Reference Bureau.
- The number of mixed-race children in the United States has quadrupled since 1970, according to the Census Bureau.
- In 1993, 3.9% of African-American women married whites, and 8.9% of African-American men had white spouses, according to *Time* magazine. (Fall 1993)

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Infant Development

Even infants need their solitude

By Ester Schaler Buchholz, PhD

Time alone — to self-regulate, organize information, reduce stimulation and rest — is a major developmental need. This need is so primary that it is equivalent to the better-researched and well-accepted need to attach. By design, the need to attach and the need to be alone are not in opposition to each other. Rather, they operate as parallel to each other. When working at their best, the two needs help to create balance in life and aid survival. And this is true starting with infancy.

These statements may sound paradoxical and even controversial, as they run counter to the prevailing psychology. In today's milieu, attachment is the be-all and end-all for healthy child development. For example, the child who plays alone is quick to be labeled as withdrawn.

It was in reaction to that climate of strict child-care and little concern about children's affectional desires that today's focus on relationships took root.

Programming children's activity from womb (expectant parents have been instructed to talk and sing to their fetuses) to school and beyond reflects the collective wisdom of the scientific community. A panel of experts recently advised the White House that without constant stimulation, we will reduce an individual's intelligence quotient and decrease the growth of brain cells.

Although some hard evidence exists, such as magnetic resonance imaging scans that match brain cell ac-

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Inside This Issue

Depressed mothers' newborns display fewer facial expressions than other newborns.
See page 3

Child abuse is common in Ontario.
See page 4

Researchers find a strong association between intrauterine exposure to maternal infections and risk of cerebral palsy.
See page 4

Guest Commentary:
Not only are millions of fathers in our prisons, but the prison has become a surrogate father to many.
See page 8

This month's client handout
"I don't wanna go to school today."

Social Policy

Spanking and hitting are perilous

By Jordan Riak

"I don't know where torture belongs, but certainly not in the classroom, not even in the jail or court. Whipping is torture and humiliation, and pain. I thought we human beings were trying to get rid of these afflictions." — Karl Menninger, MD

Whether any child, on any pretext, in any circumstance, should be subjected to physical battery, and whether such treatment is beneficial to the child, should have ceased long ago to be matters for serious debate. The fact is that the deliberate traumatization of a child by a caretaker is destructive to that child. As a teacher, I know that the battering of a child in the pelvic area with a wooden board is always pedagogically contraindicated.

Corporal punishment, also known as discipline, chastisement, spanking, switching, paddling, whupping, licking, beating, popping, bopping, whacking and belting, is torture, humiliation and pain. The use of euphemisms for violence toward kids demonstrates the penchant for self-delusion among the perpetrators.

For reasons not entirely clear, the United States seems to have a

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Resources

Be a tree, act like a log to avoid dog bites

Young children (and adults, too) need to learn some simple rules to avoid being bitten by man's best friend, according to J. Michael Cornwell, an adjunct professor of preventative medicine at Ohio State University's College of Veterinary Medicine.

"More children get bitten by dogs each year than get measles, mumps and whooping cough combined," said Cornwell in a recent issue of the *Journal of the American Veterinary Medical Association*. To nip the problem, Cornwell has developed a 15-minute video called "Animal Safety is Fun!" in which he teaches children to be a tree when approached by a dog or to act like a log if they are lying down or are knocked over by a dog.

How? Here are some of Cornwell's rules:

- Stand still with feet together, fists folded under the neck with arms and elbows against the chest. "This is a neutral, non-threatening position that minimizes the antagonism of dogs," says Cornwell.
- Look straight ahead, avoiding eye contact.
- Never run. Dogs instinctively chase moving objects. If a person stands still long enough, the dog will just get bored and leave.

Cornwell, who is a veterinarian in private practice, advises people who have been knocked down by a dog to act like a log: Lie face down with fists folded behind the neck, and forearms covering the ears. Feet and legs should be together. Contact Cornwell at (614) 268-0540 for information on how to obtain a copy of his tape.

Community initiative stresses child's first three years

New pediatric brain research suggests that the number of synapses between brain cells skyrockets before a child's third birthday, but if those connections are not reinforced by a good learning environment, they will shrink and disappear.

Educators and community leaders in Battle Creek, MI, are taking this news seriously in a community campaign designed to help parents and child-care workers.

The initiative, called "Learning Now!", emphasizes the need for the community to provide children with a stimulating environment and features free seminars and materials mailed at regular intervals during a child's developing years, from birth through age 5.

Information in the packet is designed for a loose-leaf binder and outlines practical ideas on how to develop everything from muscles to memory, and how to promote learning. The packets, which are free to the public, also include small brochures on such topics as shopping with toddlers. The shopping brochure recommends limiting shopping to less than one hour, being prepared for potty stops, taking hats and mittens off to make the child comfortable indoors and making a game out of shopping.

"Learning Now!" is sponsored by the Greater Battle Creek CEO Forum/Educator's Task Force. Materials are available by calling (616) 660-5857.

I don't wanna go to school today.

School phobia can have many sources: The key to treatment is finding out which one.

Funny how kids always seem to develop stomachaches on Sunday nights.

Maybe they're having trouble with a teacher or classmate. Maybe they just started high school in a new town. Maybe their parents are going through a divorce. Or maybe they're showing the first signs of a mental health problem, like panic attacks or social phobia.

There's lots of reasons for school phobia, say child psychologists, so assessment is the critical first step in getting help for a kid who refuses to go to school. "You really have to have some idea of what's going on," says Marjorie Pelcovits, PhD, a clinical psychologist in private practice in Providence, RI.

Easier said than done, says Dr. Pelcovits, adding that most of these kids appear to be perfectly normal. "The typical kid who demonstrates school phobia is usually a very well-behaved, high-functioning, high-achieving kid who does very well in school, has good peer relationships and gets along well with everybody, and therefore it's completely baffling why they'd be avoiding school," says Dr. Pelcovits, who is also a clinical instructor of community health at Brown University Medical School. "Most of the time, it's not so clear what the reasons are."

More girls than boys have school phobia — maybe because girls are more apt to admit to anxiety — and it's most common in the lower elementary grades. But it can happen at any age, and some researchers think that the older the child, the more severe the underlying problem.

Dr. Pelcovits says school-phobic teenagers are more likely than younger kids to be having peer problems. She describes a 15-year-old patient who got involved with the wrong crowd just before starting high school, and spent all her days hanging out with her new friends.

Continued on next page

Everyone gets nervous before the first day of school

Just because a kid is anxious about going back to school doesn't mean she's got full-blown school phobia. A little September anxiety is perfectly normal, says psychologist Marjorie Pelcovits, PhD. When she told a young patient that he seemed anxious about starting fifth grade, he said, "I thought 'anxious' meant that you can't wait to do something." "In a way it does," Dr. Pelcovits told him. "That's a funny thing because your body reacts the same way whether you're nervous-anxious or whether you're eager-anxious."

Here are some things you can do to help soothe back-to-school jitters:

Have your child visit the school and meet the teachers before the school year starts.

Introduce your child to a student who's already at the school to show him around or sit with him in the cafeteria.

Help her mentally visualize what the first day of school will be like, step-by-step, starting with where she'll wait for the bus. "When a child knows that there's nothing that they're not going to be capable of, that it's really not that unfamiliar, the routine alleviates some anxiety," Dr. Pelcovits says.

Ask what his specific worries are and brainstorm ways to address them. For example, if he's sure he'll be totally alone, help him think of ways to start conversations with new classmates.

Remind her that she probably won't be the only one who's brand new.

Remind him of times in the past when he's felt scared, and how he got through them.

Have her picture what things will be like later in the year. "Most people who are anxious picture themselves standing there at the beginning, knowing nothing, knowing nobody," Dr. Pelcovits says. "And yet by the end of the day, somehow or another, even if it's while you're standing in the line at the water fountain, you've talked to people, you know where you're going to sit, you know where you're going to go. Familiarity breeds a certain amount of comfort."

Transitions — to a new school, for example, or between junior high and high school — are a vulnerable time.

Dr. Pelcovits recommends setting a rule: "Come hell or high water, that child is going to school."

If that turns out to be impossible and the child ends up staying home, then parents should make sure the kid has a boring day. "Sometimes parents make [a day off from school] interesting, and for practical reasons too: 'If this kid's going to stay home, I need to take him with me while I do my errands,'" she says. "And so it inadvertently becomes reinforcing."

When a child is missing lots of school — and Dr. Pelcovits has had young patients who've stayed out of school for months — parents should set up a collaborative relationship with the school. "It's creating a spirit of cooperation without accusing, not saying things like, 'What are you doing to my child?' and likewise getting to the school to know that you're really doing everything that you can so that they don't say, 'Oh, it's those parents. They're coddling this child,'" she says. "We need to approach this in a unified way so that this child knows that we're all trying to assist him or her."

Parents should make arrangements with their child's teachers to get homework assignments so that he or she doesn't fall too far behind.

And parents and school professionals should decide how to get the child back to school, and whether that's best done gradually. "For kids who've been out a lot, the whole idea of reintroducing them and having them go all of a sudden for a full day is terrifying for them, even when they're finally ready to go back," Dr. Pelcovits says. "So you have to work creatively with schools to create graduated reentry programs."

She also advocates teaching kids simple anxiety-management skills that will help them feel more in control when they're walking down a crowded corridor or sitting in the cafeteria. "If there wasn't anxiety at the beginning, there is now just because they've been away from school so long and they're so overwhelmed by everything left to do and by the fact that everybody's going to be staring at them," she said. "There's a lot of face-saving involved when you've been out of school for a while." ■

The Brown University Child and Adolescent Behavior Letter

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

Keep Your Eye On

... back to sleep.

In another study of sudden infant death syndrome (SIDS), researchers at Thomas Jefferson University Hospital in Philadelphia have found that overall SIDS deaths have decreased in the United States but that the smallest decrease is seen among African-American babies.

In a study led by Eric Gibson, MD, researchers reviewed the post-neonatal mortality rates from 27 states representing 75 percent of all yearly births in the United States. When they compared SIDS rates by race, they found rates dropped in the white population by 36 percent, combined Asian and Hispanic populations by 42 percent, and in the African-American population by only 16 percent.

... rollerbladers' wrists.

The most common wrist injuries from in-line skating can be easily prevented by wearing easy-to-use and inexpensive wrist guards, according to Eric Wall, MD, director of sports medicine at the Cincinnati Children's Hospital Medical Center. The study involved 103 children who came to the emergency room with skating injuries, 46 percent of whom had wrist guards were eight times more likely to sustain a break in a skating fall than those who wore them.

... heads-up design.

Black teenagers would be more likely to wear bicycle helmets if the helmets had sports or designer logos, were promoted by sports or entertainment stars and if the helmet design were smaller, say researchers at Cincinnati Children's Hospital Medical Center. Their study involved focus groups of eighth-graders from predominantly African-American neighborhoods; 19 percent of the youths said they owned helmets.

... bottoms up.

Despite evidence that infants' sleep positions are closely related to the incidence of sudden infant death syndrome (SIDS), many child-care workers still put babies to sleep on their stomachs, according to a recent article in *Pediatrics*, the journal of the American Academy of Pediatrics (AAP).

The article reported on a study of 131 child-care facilities caring for infants younger than 6 months old in Washington, DC, and Montgomery and Prince Georges counties in Maryland. Researchers found that 49 percent of the workers placed babies on their stomachs to sleep at least some of the time and 20 percent did so exclusively. Researchers from the Children's National Medical Center in Washington also found that even when child-care staff were aware of the SIDS risk, they followed parental requests for positioning infants for naps in the manner to which they are accustomed.

The authors concluded that parents and child-care workers need more education about the importance of proper infant sleep positioning. In 1992, the AAP recommended that infants be placed on their backs or sides to reduce the risk of SIDS.

... steps in the right direction.

Lessons from the Second Step program to help children unlearn violent behavior appear to be successful, according to an article in the May 27 issue of the *Journal of the American Medical Association*. Second Step, developed in 1986 by the Committee for Children in Seattle, involves weekly or biweekly sessions to teach students in preschool to ninth grade empathy, problem-solving and anger management. A recent study analyzing results of the program shows that children in the program are involved in fewer acts of aggressive behavior than those who aren't. For reprints of the original *JAMA* article, write to Dr. David Grossman, Harborview Injury Prevention and Research Center, 325 Ninth Ave., Box 359960, Seattle, WA 98104.

What's New in Research

Mother's look affects newborn's responsiveness

Infants of depressed mothers show less frequent spontaneous facial expressions and also, in response to modeling of happy, sad and surprised facial expressions, the infants show fewer facial expressions.

Researchers from the University of Miami and James Madison University observed the facial expressions of 40 newborns of mothers with depressive symptoms using the Brazelton Neonatal Behavior Assessment Scale. In addition to fewer facial expressions, the infants also had lower activity levels, and lower robustness and endurance scores. The authors say the performance of the neonates, who were tested within 24 to 72 hours after birth, is worrisome because the infants are already at risk for being less interactive because their mothers have depression. The infants' lack of responsiveness may also make it difficult to establish a satisfying mother-child relationship, thereby making the mother more depressed, they said.

The same study points out that although little research has been done on the genetic or prenatal transmission of depressive symptoms, researchers say uterine hormonal influences need to be considered. Elevated levels of norepinephrine and cortisol have been reported in depressed mothers and their newborns. It is theorized that these stress hormones cross the placenta during the prenatal period and contribute to the infants' less-than-optimal behavior during the neonatal period.

"Newborns of mothers with depressive symptoms are less expressive," Brenda Lundy, PhD, et al., *Infant Behavior and Development* 19: 419-424, 1996. For reprints, contact Dr. Lundy, Glenville State College, Bennett Academic Center, Glenville, WV 26351.

Canadian study shows prevalence of abuse

Childhood maltreatment is common among Ontario residents, a recent report shows. A 1990 study sponsored by the Ontario Ministry of Health set out to collect information about the physical and mental health of Ontario residents. Using a random sample of 13,002 households, the survey — based on self-administered questionnaires of individuals 15 years and older — showed that child abuse was more prevalent in younger women compared with older women, but there may be a greater willingness among young women to report abuse. Results included reports of childhood abuse by males (31.2 percent) and females (21.1 percent). Sexual abuse during childhood was reported more often by females (12.8 percent) than males (4.3 percent). For females, the co-occurrence of physical and sexual abuse decreased as the respondent got older.

"Prevalence of child physical and sexual abuse in the community," Harriet L. MacMillan, MD, et al., *Journal of the American Medical Association* 278:131-135, 1997. For reprints, write to Dr. MacMillan at the Centre for Studies of Children at Risk, Hamilton Health Sciences Corp., Patterson Building, Chedoke Division, Box 2000, Hamilton, Ontario, Canada L8N 3Z5.

Intrauterine exposure to infection increases CP risk

A recent population-based study found a strong association between intrauterine exposure to maternal infection and a marked increase in the risk of cerebral palsy in infants of normal birth weight. Maternal infection was also linked with low Apgar scores, other evidence of hypertension and need for resuscitation and neonatal seizures, which are signs commonly attributed to birth asphyxia.

Maternal fever exceeding 38° C in labor was associated with risk of unexplained cerebral palsy, as was a clinical diagnosis of chorioamnionitis. Newborns exposed to maternal infection had five-minute Apgar scores below 6. Among the children with cerebral palsy, those born to mothers with infections were more often hypotensive, needed intubation, had neonatal seizures and were diagnosed with hypoxic-ischemic encephalopathy.

"Maternal infection and cerebral palsy in infants of normal birth weight," Judith K. Grether, PhD and Karin B. Nelson, MD, *Journal of the American Medical Association* 278:207-211, 1997. For reprints, write to Dr. Grether, California Birth Defects Monitoring Program, 1900 Powell St., Suite 1050, Emeryville, CA 94608-1811.

Recommended Reading

Morality in Everyday Life: Developmental Perspectives — *Melanie Killen and Daniel Hart (Eds.), Cambridge University Press, New York, 423 pages, $59.95 (hardcover), 1995, (800) 872-7423*

A collection of papers on morality in development, including authors Dale Haye, Elliot Turiel, Philip Cowan, Joan Miller, Anne Colby and William Damon. The two themes of the book are context and development. The role of culture and the prevalence in modern society of cultural and moral diversity are also emphasized.

Psychotherapy of Abused and Neglected Children — *John W. Pearce and Terry D. Pezzot-Pearce, Guilford, New York, 368 pages, $38.95 (hardcover), 1997, (800) 365-7006*

A useful compendium of information on assessment, the role of attachment and breakdown of attachment in abuse and neglect, and therapeutic techniques.

Prevention and Early Intervention: Individual Differences as Risk Factors for the Mental Health of Children — *William B. Carey and Sean C. McDevitt (Eds.), Brunner/Mazel, New York, 328 pages, $38.95 (hardcover), 1994, (800) 825-3089*

Festschrift for pioneers in temperament development Stella Chess and Alexander Thomas, this volume is a state-of-the-art treatment of their seminal work and extensive elaborations of that work by their protégés, peers and successors. Chapter authors include Ann and A.D.B. Clarke, Edward Zigler, Jerome Kagan, Michael Rutter, Judith Dunn, Edmund Gordon, Jacqueline and Richard Lerner, Robert Plomin, Sandra Scarr and other luminaries in the field of personality development.

Solitude
from page 1

tivity to a baby's receiving stimulation, palliative studies suggest that rest improves the immune system and, thus, general functioning. We do not know what degree of activity at any one time leads to optimal development, what percentage of solitude will ensure the assimilation of information or, more importantly, whether these stimulated babies and children will evolve into adults with a keen mind. After all, Albert Einstein didn't speak until the age of 4, and spent many long hours alone.

A reaction to strictness

The importance of an aloneness need is occluded today by an unrelenting emphasis on relating and the persistent pursuit of information. But as social scientists, we have to remember that not long ago researchers such as John B. Watson were transmitting through government publications a very different philosophy on child development. In one, *Infant Care*, Mrs. Max West writes about a baby's self-sufficiency, saying a baby "should be taught to sit on the floor or in his pen or his crib during part of his waking hours, or he will be very likely to make too great demands upon the mother's strength."

It was in reaction to that climate of strict child-care and little concern about children's affectional desires that today's focus on relationships took root.

Reviewing attachment and separation-anxiety literature, starting with the foremost contributors such as Mary Ainsworth and John Bowlby, I found that attachment theory grew out of studies of maternal deprivation, untimely loss and separation, and in general, attachment under stress. On the other hand, one could look at work on overprotective parents, intrusive parenting causing narcissism and loneliness, and smothering relationships interfering with normal development, and use equally negative cases to demonstrate our need for aloneness.

Well-baby research

Following in the footsteps of infant researchers who have looked at well babies, my research assistants and I designed an in-depth observational study of three mothers and babies. We monitored the pairs for one hour a week from birth through 8 weeks, watching engagement and disengagement patterns.

We were prepared to see demonstrations of alone moments. Donald Woods Winnicott wrote about the capacity to be alone as important to emotional maturation. He spoke of it as an achievement growing from a baby's relationship to the mother within the security of the positive holding environment that the good enough mother provides. We were unprepared to see the extent of this need, including the fact that even after sufficient hours of sleep the baby looked for ways to disengage while awake. Nor did we anticipate the infants' readiness to self-soothe while alone.

Regardless of the style of interaction, each mother-baby pair seemed to work toward creating a balance of related and unrelated time. One pair in particular struggled to find that equilibrium, with the baby leading the way. We recognized the cues -- his precocious turning of the head, obvious fussing at times when picked up by a highly attentive mother and contented relaxing when put down -- as demonstrations of the power of the need for time alone, even at this tender age. The mother finally said to her baby after several weeks, "Thank God for your feeding chair. You really like that." And she learned to turn away for short periods from her self-modulating infant.

In the womb

The foundation for comforting and "comfortable alone" states is in the womb. Proprioceptors, for example, send signals to the fetal brain of changes in muscles, tendons and the like. This inner sensory system aids regulation, feeds our conscious and unconscious feelings and helps us to monitor body processes.

Early on, intrauterine experiences provide a sense of equilibrium. Monitoring devices have led us to focus on fetal distress. But the primary experience in the womb seems to be one of equilibrium. Fetal photography and ultrasound show fetuses thumb suck-

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ing, lapping up amniotic fluid and other self-soothing behaviors, all before consciousness of another.

Even at that early stage, it has been demonstrated that certain neuronal structures are key to later mental processing and self-regulation. The continuity between intrauterine life and earliest infancy that Freud surmised has been captured in the sonographic work of Alexandra Piontello and the micro-photography of Lennart Nilssen. Such reveal the foundation of alone behaviors.

People dismissing as a gas bubble what Robert Emde identified as a newborn's exogenous smile suggests a narrow, egocentric vision in which an infant's gratification can only revolve around the caretaker. But other observations of neonates also seem misinterpretable. For example, the grasping reflex is regularly viewed as a precursor to attachment needs. But it is a general learning tool. The monkey needs to grasp onto parent and tree at different times for survival.

T. Berry Brazelton supports the notion that babies through touch relax themselves. Louis Sander views the sleep-wake cycle of a 24-hour period as setting the background for the infant's recurrent experiences of inner states and as a well-coordinated, competent system for achieving a sense of agency. I see an inherent need for aloneness in Sander's suggestion of early periods of disengagement and also interpret sleep as a way of providing time alone, especially during our most dependent periods.

Monitoring devices have led us to focus on fetal distress. But the primary experience in the womb seems to be one of equilibrium.

Chase and dodge

Babies can teach the well-attuned some of their needs. The exuberant caretakers who constantly fondle and stimulate babies to help them gain intelligence and alertness will notice after a while infants ducking, closing or covering their eyes, trying to deflect some of this eagerness to relate. In psychological terms this is called "chase and dodge." Behaviorally, through self-regulation, the baby is seeking time alone to de-stimulate.

In earlier days babies were automatically allowed to settle down on their own as mothers were not heralded as providers of full-time amusement and a father was not expected to be involved. The psychology of earlier days had to be corrected to take attachment needs into consideration. Now the pendulum has swung too far in the other direction.

Culture does not support the notion of being by oneself in a positive solitude; instead it is associated with antisocial acts, fear, loneliness and death. That is why I offer the word "alonetime" as on a par with attachment.

Just as the need for attachment is not the same as "wanting smothering," so the need for alonetime does not mean the baby will be lonely. ■

Ester Schaler Buchholz is the author of *The Call of Solitude: Alonetime in a World of Attachment* (Simon and Schuster, (800) 223-2336). She is a professor at New York University in the applied psychology department and director of the Psychology of Parenthood Program. A clinical psychologist, she is also coordinator of psychoanalytic training at the Institute for Child, Adolescent and Parent Studies in New York.

Spanking

from page 1

special taste for the use of physical punishment as a technique for changing behavior and instilling morality. Not one European country legally condones the hitting of schoolchildren, and nowhere is there a discernible European teachers' movement to repeal the prohibition. In Norway, Sweden, Finland, Denmark, Austria, Cyprus and Italy, moreover, parents are not even legally permitted to hit children in the home.

In Italy, Supreme Court Judge Francesco Ippolito said that the court's decision to completely ban corporal punishment of children was seen as a step toward addressing violence against children more generally.

In the United States, 23 states still have laws permitting teachers to hit children. All states still allow parents to hit their own children. Some states have implemented "guidelines" for administering corporal punishment; for example, an adult witness must be present during a paddling. This kind of safeguard may protect the spanker legally, but does not address the cruelty of the physical punishment itself.

The legal right of parents to use physical violence against their children is, in some states, enshrined in statutes using ambiguous, unenforceable, self-contradictory and, in my opinion, duplicitous verbiage. For example, in California, "Child abuse is a physical injury which is inflicted by other than accidental means on a child by another person. It also includes emotional abuse and sexual abuse. It does not include spanking that is reasonable and age appropriate and does not expose the child to risk of serious injury."

Some of our citizens cling to the anachronistic notion that children are chattels and that their owners have a right, and are even dutybound, to control their property by violent means and may assign that right to others, such as teachers. The Proverbs of King Solomon have been cited, on occasion, as their authority; they contend that the right to won slaves (and, by extension, children) derives from Leviticus 25:44-46 and that what they do with their property is nobody else's business.

My hunch is that fundamentalists' fondness for Old Testament authority in regard to physical punishment is driven by a need for self-exculpation over their mistreatment of children. Politicians quake at provoking powerful groups that defend the rights of adults to spank children. When Hillary Clinton said, "The causes of younger children have not fared well, partly because these representatives have loyalties diluted by conflicts between children's rights and their own institutional and professional goals," she might have said instead, "The causes of politicians fare better when they avoid issues involving children."

President Clinton sprang into action to protect schoolchildren from the health risks of tainted imported berries. Only foreign berry exporters might have objected. But on the issue of one-third of a million children being beaten on their buttocks with wooden boards, he deferred to subordinates, to wit: "With regard to your specific request for advice regarding discipline policies, I must inform you that this matter must be resolved at the state and local level." — William Modzeleski, Director, Safe and Drug-Free Schools, U.S. Dept. of Education, April 9, 1997.

Riak's three-step prescription for reform

1. **Change the law.** Laws that promote child battery must be rescinded. As long as they remain, children will be assaulted and battered. Schools in paddling states will be safe havens for people who should not have access to children. Abusive teachers and school administrators will claim they are merely following parents' wishes, and abiding by the law.

2. **Teach the teachers.** Teacher-training institutions must break their silence on corporal punishment. They must teach not to hit, and must take an unequivocal position against corporal punishment. Any education student subscribing to corporal punishment as a legitimate means of instruction should be regarded in the same light as a medical student who persists in believing that washing hands between patient examinations is unnecessary.

3. **Inform the public.** Responsible parents today do not tolerate having their children ride in a school bus with faulty brakes. They will not allow their children to sit in a classroom contaminated with asbestos or lead-based paint. It should be equally intolerable to be required by law to entrust the care of one's child to credentialed hitters.

The "state level" furthers the abrogation of authority with, for example: "Discipline policies are made at the local district level based on Arizona statutes. I do not have jurisdiction in this matter." — Lisa Graham Keegan, Superintendent of Public Instruction, Arizona Dept. of Education.

But a rapid decline of spanking noted by pollsters over the past two decades suggests that the stage is being set for a violence-free school system in the United States. A new generation of properly prepared teachers should be able to resist the corrupting influence of the hitters and the hitters' apologists. As teachers demonstrate their success with non-violent management of children, they will become appropriate community models and receive the support that non-violence toward children deserves.

"An intelligent and well-trained teaching profession will reconstruct education along lines which do not tolerate the use of coercion, thus reinforcing enlightened public opinion and in turn being reinforced by it." — Herbert Arnold Falk, PhD, "Corporal Punishment: A Social Interpretation of its Theory and Practice in the Schools of the United States," Teachers College, Columbia University Contributions to Education, 1941. ■

Jordan Riak, a former teacher, is founder and executive director of Parents and Teachers Against Violence in Education (PTAVE), a nonprofit children's rights advocacy organization. You may fax him at (510) 838-8914, or visit his Web site, "Project NoSpank" at http://silcon.com/~ptave.

BEST COPY AVAILABLE

Guest Commentary

Son, meet Dad:
The American prison becomes a surrogate father

By Michael J. Murphy, EdD, DFP

If there is one thing I have learned in my years as a prison-based forensic psychologist, it is that we, as a nation and as a profession, face two gigantic problems: the steep growth of prisons and fatherlessness.

The numbers in prison in America are staggering: 2 million men are locked up in various facilities at any given moment, and over the course of a given year, more than 10 million American men pass through our correctional institutions. It can be said without exaggeration that the Department of Justice is well on the way to becoming the primary provider of socializing influence for the majority of American men.

It may be no coincidence that the entry of millions of men into the prison system has coincided with the departure of the father from the American family. My informal research, based on interviews with thousands of male inmates, indicated that about four out of five had no consistent caretaking male figure in their lives. They are excessively dependent on women, and often violent toward women, in part because they are terribly uncomfortable when confronted by an older man. Completely bereft of pathways toward supportive intimacy with older men, they rush headlong to dominate the nearest woman.

While a minority of American fathers are more deeply involved in the details of child-care than ever before, for the first time in history the majority of American children are fatherless.

When a desperate single mother asks me how she can fill the father-void in her son's life, I offer the usual litany: Big Brothers, Boy Scouts, uncles, coaches. But the silent truth is that for many young men, the closest thing to a father they will ever experience is the prison.

The prison offers limits, structure and rewards for good behavior, all managed and provided by older men. Another terrible truth is that many young men thrive in prison; it is only in the community, where there are no surrogate parent figures guiding every decision, that failure, and renewed punishment, await.

What has disappeared from the lives of the majority of Americans is the "good enough father" — the guy who consistently represents an ethic of hard work, discipline and silent love. He may have had faults aplenty, but he had one great asset: He was there. When he disappeared, along with him went the thousands of moments in which he modeled appropriate behavior and impulse control, and filled in the space in a child's mind when he or she said the word "father."

When I asked one young court-referred defendant to tell me who came to mind when I said the word "father," he fell silent for long minutes. Finally, this 19-year-old raised his head and smiled. "JFK!" he announced proudly.

That the only father figure he could imagine was an ex-president assassinated long before he was born did not augur well for this young man's future. I knew that his search for a male image would carry him to the American heartland of masculinity — the prison.

Not only must we address the correlation between fatherlessness and imprisonment, we also must face the exploding numbers of American children whose parents are themselves in prison. More and more prisons are coming to the common-sense conclusion that imprisoned women need to spend more time with their children. Visiting hours and facilities need to be expanded. But no such suggestions are offered on behalf of the 80 percent of inmates who are fathers. More and more frequently they must confront the oxymoronically named "no contact visit," in which an anguished 2-year-old desperately scrapes the Plexiglas that shields him from his father's hand.

I am not naive enough to believe that psychologists and psychiatrists can profoundly alter the massive social forces propelling the escalation of fatherlessness and imprisonment. Nonetheless, we should understand where the nation is headed as the numbers continue their upward spiral. I am convinced that, although the problem is global, the solution is local: individual men consistently caring for individual children. Whether the forces motivating the growth of imprisonment and fatherlessness or those supporting the responsible contact between men and their children will win the race is a mystery to me, but each one of us, through our compassionate awareness, must do our small part. ■

Michael Murphy is a psychologist for the Massachusetts Department of Corrections and an adjunct faculty member at Lesley College graduate school. He is the author of *Popsicle Fish: Tales of Fathering*. You can write to him at 25 Monument Road, Orleans, MA 02653.

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Providing the link between behavioral research and your clinical work.

Identity Development

"Why are all the black kids sitting together in the cafeteria?"

By Beverly Daniel Tatum, PhD

Walk into any racially mixed high school cafeteria at lunch time and you will instantly notice an identifiable group of black students sitting together. Conversely, there are many white students sitting together, though we rarely comment about that. The question is "Why are the black kids sitting together?"

It doesn't start out that way. In racially mixed elementary schools, you often see children of diverse racial backgrounds playing with one another, sitting at snack tables together, crossing racial boundaries with an ease uncommon in adolescence.

> ***In racially mixed settings, racial grouping is a developmental process in response to an environmental stressor, racism.***

Moving from elementary school to middle school means interacting with new children from different neighborhoods than before, and a certain degree of clustering by race might therefore be expected, presuming that children who are familiar with one another would form groups. But even in schools where the same children stay together from kindergarten through eighth grade, racial grouping begins by the sixth or seventh grade. What happens?

One thing that happens is puberty. As children enter adolescence, they begin to explore the question of identity, asking "Who am I? Who can I be?" in ways they have not done before.

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This month's client handout
12 timely tips on communicating with kids

Case Study

Mobilize parents when treating children's behavioral problems

By Jeffrey A. Botman, PhD

During my early years of training, I practiced at a psychiatric clinic where children were treated with expressive-play therapy, aimed at helping them work through their troubled conduct. The goal of the therapy was to clarify the unconscious meanings of the children's disturbed conduct in light of their feelings about self and world — feelings that may have been derived from emotionally traumatic past events.

In contrast, a strategically-oriented approach to therapy presupposes that the road leading to resolution of children's psychological problems may stand independent of the traumatic events from which they derive. The strategic therapist maintains that psychological traumata result in specific obstacles to normal childhood learning, whether those obstacles involve:

- Crippling beliefs about self, other or world.
- Constricting relationships.
- Affective responses, which automatically disrupt processes of self-regulation.

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The Brown University **Child and Adolescent Behavior Letter**

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Keep Your Eye On

... home visits.

After 15 years of research into what makes home visits successful, homes of first-time, low-income, unmarried mothers are being opened to visiting nurses from the Home Visiting 2000 project in Denver, CO.

Developed by David Olds at the University of Colorado Health Sciences Center and Harriet Kitzman of the University of Rochester Medical Center, the project uses professional nurses to visit the new mothers at their own homes. Visits last at least 90 minutes — or long enough to build a bond sufficient to enable the visiting nurse to help families address social, personal and health needs with a comprehensive, flexible approach.

The program starts before the mother's baby is born and continues through the child's second birthday. The nurses' work can range from getting down on the floor and playing with building blocks with mothers and babies to helping parents sort through issues of the child's healthy emotional development to educating mothers about the importance of good nutrition. For information, contact Pilar Baca at (303) 861-1715. (*Children's Advocate*, July/August, 1997)

... high expectations.

Parents' expressions of disappointment may be the best reproach for children's bad behavior, according to researchers at Ohio State University. Statements such as "I would never expect you to do something like that," were found to be more helpful for disciplining sixth and seventh graders than other forms of punishment.

According to the study, this type of inductive discipline, in which parents ask children to behave in a better fashion and explain the negative consequences of their misbehavior for others, produces higher levels of empathy and more helpful behavior in children. For more information, contact John Gibbs at (614) 292-7918 or Julia Krevans at (216) 381-5014.

... write stuff.

A Denver handwriting specialist has developed a new program of handwriting and music therapy that helps learning-disabled children read and write. Using a unique template with specially selected music, Jeanette Farmer "retrains the brain" and teaches the students to form patterns that stimulate the brain and open undeveloped neural pathways. For more information, contact Farmer at (303) 740-6161.

... anorexia and strep.

Researchers are looking into the possibility that a bacterial infection, a beta-hemolytic streptococcal (GABHS) bacterium, could be the trigger for anorexia nervosa. According to a recent study in the *Journal of the American Academy of Child and Adolescent Psychiatry*, one 12-year-old boy developed worsening symptoms of anorexia after a bout with strep. Anorexia was also reported in two cases of teens with Epstein-Barr and in both cases, the symptoms tended to wane as health improved. (*Journal of the American Academy of Child and Adolescent Psychiatry* 38:1128-1132,1997)

... no problem.

Most teenage girls with eating disorders don't believe they need help, according to a presentation at the American Psychological Association's annual meeting in Chicago. Dinah Meyer, PhD, said that the results of her research show that eating disorders have become so common among adolescent girls that they are often not considered a problem. After all, their friends do it, too. The research also showed that girls don't seek help because they fear counseling, according to a press release from Ohio State University, where Meyer serves as assistant professor of psychology at the university's Marion Campus. Meyer can be reached at (614) 389-6234.

... new approach for autism.

Changes in diet and environment are the focus of new approaches for treatment of autism and will be the focus of a Nov. 15 conference in New York sponsored by the nonprofit Feingold Association. For more information, contact the association at (800) 321-3287.

... once-a-day asthma relief.

A new once-a-day tablet for controlling chronic asthma in adults and children has been approved for sale in Finland. The drug marketed under the name SINGULAIR (montelukast sodium) by Merck & Co. Inc., is a member of a new class of medicines known as leukotriene receptor antagonists. Leukotrienes are associated with a number of problems, including airway constriction and inflammation.

What's New in Research

Depersonalization is not uncommon

A new study suggests that depersonalization, once thought to be a relatively rare disorder, may be more prevalent than expected, with onset beginning in mid- adolescence.

Researchers designed an experiment to characterize the phenomenology, comorbidity, traumatic antecedents and treatment history of the disease in 30 consecutively recruited adults, using the self-report Dissociative Experiences Scale and a semi-structured interview on all aspects of their depersonalization histories.

Subjects reported varying degrees of distress and interpersonal impairment, and reported significantly more childhood trauma than the normal comparison group. The disorder, which was twice as common in women as men, usually had a chronic course that waxed and waned in intensity, but was sometimes episodic. The researchers characterized the disorder as treatment refractory and found that only serotonin reuptake inhibitors and benzodiazepines (to a lesser degree) had any therapeutic benefit.

"Feeling unreal: 30 cases of DSM-III-R Depersonalization Disorder," Daphne Simeon, MD, et al., *American Journal of Psychiatry* 154(8):1107-1112, 1997. For reprints, contact Dr. Simeon, Psychiatry Box #1230, Mount Sinai School of Medicine, One Gustave L. Levy Pl., New York, NY 10029.

Security blanket or Mom — not both

A new study has found that a 3-year-old child's security blanket is just as soothing as the presence of the child's mother during routine, non-invasive medical examinations. But researchers suggest that having mom and the security blanket present at the same time might be worse than letting the doctor examine the child accompanied only by the blanket.

Gabriel Ybarra, MS, a department of psychology researcher at University of Wisconsin-Milwaukee, and colleagues, observed 64 three-year-old children, some of whom were attached to their blankets and others who weren't.

Eight children in each of eight groups went for a routine noninvasive examination with their blanket alone, with their mother alone, with both mother and blanket and without blanket or mother.

"If the child was attached to a security blanket, then it served as a useful substitute for a mother and helped the child get through the exam with little distress," says Richard Passman, PhD, of the university's department of psychology and its Early Childhood Research Center. But the study showed a small negative difference when those children who were attached to their blanket were also accompanied by their mother.

Ybarra suggested that the doubling up of comfort items — blanket and mother — predisposed the child to expect problems.

Based on interviews with Gabriel Ybarra and his presentation of a paper, "Security Blanket or Mother: Which Benefits Linus During Pediatric Examinations?" by Ybarra and Richard Passman, University of Wisconsin-Milwaukee; and Carl Eisenberg, Milwaukee Medical Clinic. Presented at the 105th annual meeting of the American Psychological Association, Chicago.

Eating with teens improves their level of adjustment

If you insist that your teenagers sit down and have at least one meal a day with an adult you will substantially reduce their risk of being considered maladjusted, according to a recent study.

Researchers are not sure what happens when 12- to 19-year-olds eat meals with adults, either at home or in a restaurant, but something positive occurs, says Blake Bowden, PhD, a senior fellow in neurodevelopmental disorders at Cincinnati Children's Hospital Medical Center.

"It doesn't matter if the meals are with one or both parents or grandparents," Bowden says. "The study shows that the 'adjusted' teenagers eat meals with adults about five days a week, but 'non-adjusted' teens eat meals with adults just three days a week."

The researchers noted that previous studies have found links between adolescents' mealtimes with adults and academic success. And other studies have seen increases in alcoholism as shared mealtimes decrease.

Bowden and colleague Jennie Zeisz, PhD, of the department of psychology at DePaul University in Chicago, studied 527 rural adolescents ages 12 to 18, and characterized them on the basis of their substance use or abuse, depression or hopefulness, academic motivation and peer relationships.

In the study, 176 youths were deemed "adjusted," while 351 were "non-adjusted." Just by looking at mealtimes spent with adults, researchers had a 75 percent success rate predicting into which category the adolescents would fall. The adjusted youths ate meals with adults, on average, 5.389 days per week; the non-adjusted youths dined with adults, on average, 3.344 days per week.

While Bowden says family mealtimes are strongly related to adjustment, he doesn't know exactly why. He suggests it could be related to communication between adults and adolescents during mealtimes; it could help confirm a child's importance as a member of the family by giving that child added self-esteem; or it could imply a more structured lifestyle that carries over into other behaviors. Bowden believes it's likely the mealtime-eating phenomenon is simply a marker of something else going on in the family that translates into more acceptable behavior.

While he admits that the study did not look at using mealtime as an intervention, he says that the added time together in which adult habits could rub off on children would likely prove to be a positive step in correcting objectionable behavior.

From a presentation by Blake Bowden, PhD, at the 105th annual meeting of the American Psychological Association, Chicago.

Resources

Di's children benefit from nation grieving

In the wake of the tragic death of Princess Diana, many are left with the sad image of two young boys facing the future without their mother. Lynn Davidman, a professor at Brown University and the author of an upcoming book *Growing Up Motherless: Stories of Lives Interrupted*, to be published by the University of California Press, addresses this topic. In her interviews with 60 adults, she found that the freedom to talk about and express their feelings can help adolescents deal with the pain of their loss. Davidman's interviews revealed that silence surrounding a mother's death creates an aura of shame and embarrassment and feeds a sense of isolation about the event. Davidman, a sociologist, says that Princes William, 15, and Harry, 12, are taking a healthier road with a whole nation supporting them and allowing them to grieve.

Extension offers information on constructive discipline

For parents at their wit's end with misbehaving children, Cornell Cooperative Extension suggests that "discipline" isn't necessarily harsh or unpleasant. The extension offers a 4-page fact sheet entitled, *Discipline: What Is It?* that lists seven principles of constructive discipline. It also includes a 24-page bulletin, *Discipline Is Not a Dirty Word*, with practical examples that show how to correct children's behavior. The fact sheet and bulletin, written by child development specialist Jennifer Birckmayer, is a revision of the popular first edition. Both publications may be obtained from the Cornell University Media Services Resource Center, 8 BTP, Ithaca, NY 14850. The charge is $2 per copy for *Discipline: What Is It?* (321HDFS38) and $5.50 per copy for *Discipline Is Not a Dirty Word* (321HDFS51). The prices include postage, handling and a free list of related materials. New York residents should add applicable sales tax.

Twelve timely tips on communicating with kids

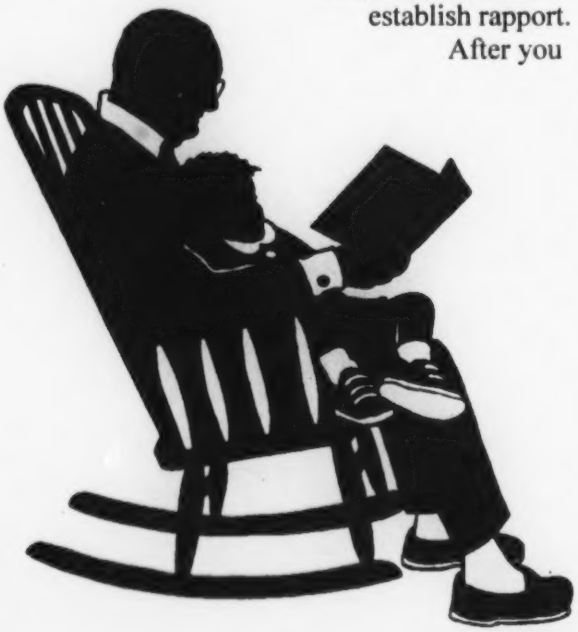
by Phillip Mountrose

What can you do to get through to kids? Many of the problems in our society reflect a breakdown in communication between adults and children. John Bradshaw observes that "the reason families have become stuck and dysfunctional, even for generations, is because of their inability to cope with stress and come up with strategies that work."

A vital resource for "coming up with strategies that work" is the kids themselves. Many times we are unaware of a youngster's ability to problem solve and, as a result, we habitually make decisions for the child. But when kids to participate in solving problems, their thinking and listening skills improve. Their self-esteem grows. Here are 12 powerful and practical tips you can use to turn things around — for yourself and your kids:

Tip 1: Approximate the child's posture.

If the child is sitting, you sit. If standing, you stand. If arms are folded, fold your arms. Relating to the child's body language will establish rapport. After you gain rapport, you can lead the child into more open, relaxed body language if needed.



Tip 2: Allow the child to say as much as possible.

The aim is to have the child reach the conclusion. You need only offer minimal guidance and words. The talk can also open up other issues and meaningful discussions between you and the child.

Tip 3: Listen carefully for the child's feelings, thoughts and beliefs.

Allow to child to really express himself. The child will feel your care and respect when you closely hear his words.

Tip 4: Use the child's key words when communicating with her.

But be careful not to mimic or be too repetitive with her own words. If the child says, "No one likes me," you can respond, "So, no one likes you. Has anyone ever liked you?"

Tip 5: Avoid trying to "fix" things for the child or rescue him.

By giving the child answers to problems, you deprive him of learning.

Tip 6: Be concrete, using terms she understands.

The younger the child, the simpler the language. She may need help articulating thoughts and feelings, but keep it simple.

Tip 7: Allow for periods of silence in the communication.

Problem-solving can take time to unfold. Children need more time to understand their internal world than adults. Be patient.

... Continued on next page

Tip 8: You need to be calm enough yourself to process with the child.

Take some deep breaths or wait until you can talk with a neutral open attitude. This will help your thinking and listening skills as well as the child's.

Tip 9: The child needs to be willing to speak about the problem.

If the child is too disturbed or in denial about the problem, find another time to talk. The right time might be minutes or days later.

Tip 10: If the child's problem directly affects you, share your thoughts and feelings with the child.

Be aware of when the situation affects your responsibility, time or money. Then work out a solution with the child that is mutually acceptable. Find a way to honor both you and the child.

Tip 11: Remember to have the child discover the solution whenever possible.

This way he is likely to carry it out and internalize the learning.

Tip 12: Ask the child for information and solutions rather than telling her answers.

The child will generally arrive at the solutions herself from your questions. Careful listening to the child will help her concentrate and think for herself.

Put these tips into practice. Help your communication with kids become clear, easy and effective.

Phillip Mountrose has educated children of all ages for over 20 years. He has created inspiring instructional videos used nationwide. From *Getting Thru to Kids: Problem Solving with Children Ages 6 to 18* by Phillip Mountrose, copyright 1996, Phillip Mountrose. Reprinted by arrangement with Holistic Productions. To order the book ($14.95 postpaid), please call (800) 644-5437 or write to Holistic Productions, P.O. Box 41152, Sacramento, CA 95841-0152.

The Brown University **Child and Adolescent Behavior Letter**

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Recommended Reading

SOLUTION-FOCUSED THERAPY WITH CHILDREN: HARNESSING FAMILY STRENGTHS FOR SYSTEMIC CHANGE — *Matthew D. Selekman, Guilford, New York, 250 pages, $27.95 (hardcover); (800) 365-7006.*

Described by reviewers as charming, inventive and joyful, this volume is dedicated to the thesis that children with emotional and behavioral problems can be treated effectively in short-term managed-care contexts.

ADOLESCENT COPING: THEORETICAL AND RESEARCH PERSPECTIVES — *Erica Frydenberg, Routledge, New York, 233 pages, $24.95 (paperback); (800) 634-7064.*

Through the voices of young people, the Australian author of this book focuses on how young people manage life problems, and especially on the coping styles of special groups such as the gifted or those with chronic illnesses.

Racial identity

from page 1

For black youths, asking "Who am I?" includes thinking about "Who I am ethnically? What does it mean to be black?"

Why do black youths, in particular, think about themselves in terms of race? Because that is how the rest of the world thinks of them. Our self-perceptions are shaped by the messages we receive from those around us, and when young black men and women reach adolescence, the racial content of those messages intensifies.

Here is a case in point. If you were to ask my 10-year-old son, David, to describe himself, he would tell you many things: that he is smart, that he likes to play computer games, that he has an older brother. Near the top of his list, he would likely mention that he is tall for his age. He would probably not mention that he is black, though he certainly knows that he is. Why would he mention his height and not his racial group membership?

When David meets new adults, one of the first questions they ask is "How old are you?" When David states his age, the inevitable reply is, "Gee, you're tall for your age!"

It happens so frequently that I once overheard David say to someone, "Don't say it, I know. I'm tall for my age." Height is salient for David because it's salient for others.

When David meets new adults, they don't say, "Gee, you're black for your age!" Or do they?

Imagine David at 15, six-foot-two, wearing the adolescent attire of the day, passing adults he doesn't know on the sidewalk. Do the women hold their purses a little tighter, maybe even cross the street to avoid him? Does he hear the sound of automatic door locks on cars as he passes by? Is he being followed around by the security guards at the local mall? Do strangers assume he plays basketball? Each of these experiences conveys a racial message.

At 10, race is not yet salient for David, because it's not yet salient for society. But it will be.

Understanding racial identity development

Psychologist William Cross, author of *Shades of Black: Diversity in African American Identity*, has offered a theory of racial identity development that I have found to be a very useful framework for understanding what is happening with those black students in the cafeteria. In the first stage of Cross's five-stage model, the black child absorbs many of the beliefs and values of the dominant white culture, including the idea that it's better to be white.

Simply as a function of being socialized in a Eurocentric culture, some black children may begin to value the role models, lifestyles and images of beauty represented by the dominant group more highly than those of their own cultural group. But the personal and social significance of one's racial group membership has not yet been realized, and racial identity is not yet under examination.

The encounter stage

Transition to the next stage, the encounter stage, is typically precipitated by an event — or series of events — that forces the young person to acknowledge the personal impact of racism.

For example, in racially mixed schools, black children are much more likely to be in a lower track than in an honors track. Such apparent sorting along racial lines sends a message about what it means to be black. One young honors student said, "It was really a very paradoxical existence, here I am in a school that's 35 percent black, you know, and I'm the only black in my class. That always struck me as odd. I guess I felt that I was different from the other blacks because of that."

There are also changes in the social dynamics outside the school. In racially mixed communities, you begin to see what I call the "birthday party effect." The parties of elementary school children may be segregated by gender, but not by race. At puberty, when the parties become sleepovers or boy-girl events, they become less and less racially diverse.

Black girls who live in predominantly white neighborhoods see their white friends start to date before they do. One young woman from a Philadelphia suburb described herself as "pursuing white guys throughout high school" to no avail. Because there were no black boys in her class, she had little choice. She would feel "really pissed off" that those same white boys would date her white friends.

Another young black woman attending a desegregated school to which she was bussed was encouraged by a teacher to attend the upcoming school dance. Most of the black students did not live in the neighborhood and seldom attended the extracurricular activities. The young woman indicated that she wasn't planning to come. Finally the well-intentioned teacher said, "Oh come on, I know you people love to dance." This young woman got the message.

Coping with encounter

What do these encounters have to do with the cafeteria? Do experiences with racism inevitably result in so-called self-segregation?

While a desire to protect oneself from further offense is understandable, it's not the only factor at work. Imagine the young eighth-grade girl who experienced the teacher's use of "you people" and the dancing stereotype as a racial affront. Upset and struggling with adolescent embarrassment, she bumps into a white friend who can see that something is wrong. She explains. Her white friend responds — perhaps in an effort to make her feel better — and says, "Oh, Mr. Smith is such a nice guy, I'm sure he didn't mean it like that. Don't be so sensitive."

Perhaps the white friend is right, but imagine your own response when you are upset, and your partner brushes off your complaint, attributing it to your being oversensitive. What happens to your emotional thermostat? It escalates. When feelings, rational or irrational, are invalidated, most people disengage. They not only choose to discontinue the conversation but are more likely to turn to someone who will understand their perspective.

In much the same way that the eighth-grade girl's white friend doesn't get it, the girls at the "black table" do. Not only are black adolescents encountering racism and reflecting on their identity, but their white peers — even if not racist — are unprepared to respond in supportive ways.

The black students turn to each other for the much needed support they are not likely to find anywhere else.

We need to understand that in racially mixed settings, racial grouping is a developmental process in response to an environmental stressor, racism. Joining with one's peers for support in the face of stress is a positive coping strategy. The problem is that our young people are operating with a very limited definition of what it means to be Black, based largely on cultural stereotypes. ■

Beverly Daniel Tatum is a professor at Mount Holyoke College and a psychologist in private practice. This article is excerpted with permission from her book, *"Why Are All the Black Kids Sitting Together in the Cafeteria?" And Other Conversations About Race,* Basic Books, $24 hardcover; 270 pages. To order, call (800) 331-3761.

Parenting

from page 1

- Cognitive and behavioral skill deficits.

Strategic therapy aims to overcome those same obstacles to learning by orchestrating therapeutic tasks, which lead the child to developmentally liberating experiences that:

- Transform beliefs about self, other and world.
- Restructure relationships.
- Provide emotional relief, leading to gains in self-regulation.
- Enhance cognitive and behavioral skills.

To form a strategic intervention with a child, begin with simple questions for the parents:

- What must the child learn?
- How best can you teach the child what he/she must learn?

Case study

The following case illustrates how a strategic therapist might mobilize parents for an intervention in their child's behalf.

The Smiths came to me for help with their son, Randy, whom they described as uncooperative.

"He won't listen to me, whether I ask him to do his homework, take out the garbage, wash his hands before dinner, get ready for school or use his inhaler for his asthma," Mrs. Smith complained.

"And I feel so angry and helpless because he just ignores me unless I'm in a fury," she continued. "My husband says I overreact, but it's not just me. His teacher says he's the same way at school."

Meeting alone with Randy, an

individually-oriented child therapist might have been inclined to explore questions of anger through expressive-play and gentle discussion. With whom was Randy angry? For what reasons? How appropriate was his anger? How much of his anger resulted from an unconsciously held grudge or hurt or fear? How else might Randy have expressed his anger? What did he fear from compliance?

Operating strategically, I sought to mobilize Randy's parents as therapeutic agents. My first step toward intervention involved identifying a single target for behavioral focus. Both parents agreed that encouraging Randy's compliance with his asthma regimen was their highest priority.

Coercion or instruction?

My second step toward intervention involved clarifying with Mr. and Mrs. Smith the difference between: (1) Coercion: forcing Randy to use his inhaler now; and (2) Instruction: teaching Randy how to use his inhaler at some future time.

After addressing the Smiths' questions and concerns, I instructed them in the following way:

"From now on, Mom and Dad, the two of you will work together as a team to teach Randy how to use his inhaler independently three months from now."

I continued: "Your job, Mom, is changing. You are to become a score-keeper instead of an enforcer. That means you will no longer ensure that your son uses his inhaler each day after school. If Randy fails to use his inhaler within 15 minutes after he returns home from school, you will simply report his failure to your husband when he returns from work.

"In such a case, the two of you will together approach Randy — as a team.

"In your son's presence, you, Mom, will announce to Dad, 'Randy did not use his inhaler today when he came home from school.'

"Then you will leave your son to his father."

I continued my instructions as follows: "Now, Dad, your job begins. You will announce to Randy, 'You haven't learned yet how to enter the house properly after school. So I'm going to teach you.'

"With that, you will escort your son back to the front porch, fully dressed in his school clothes, including his coat and hat and carrying his fully-packed book bag, just as he would have appeared upon his return home at the end of the school day.

"And you will supervise your son's re-entry into the house, ensuring that he hangs up his coat and hat, stows his book bag and uses his inhaler."

'Your job, Mom, is changing. You are to become a score-keeper instead of an enforcer.'

An in vivo context

Through this strategic intervention, the Smiths would be creating an in vivo context within which Randy could learn how to use his inhaler, much as a basketball team learns its offensive plays through practice on the court against a defensive squad.

That context would invoke a powerful teaching principle, called overcorrection, by ensuring that Randy pay a higher price for failing to use his inhaler than he would for using it immediately after school. (Each failure to use his inhaler on his own would result in the added inconvenience of getting dressed in preparation for a therapeutic practice session, as well as the necessity to hang up his hat and coat and stow his books — all under Dad's scrutiny.)

In addition, Randy's relationship with his parents would undergo restructuring as the alliance between mother and father on his behalf is strengthened and Dad's involvement in his daily routine is increased. As a consequence, Randy's estimation of his own power and his mother's authority would necessarily require assessment, and he would experience fewer conflicts with his mother.

Finally, Randy would gain basic skills in self-organization and self-discipline.

A success story

When Mr. And Mrs. Smith returned two weeks later, they could barely contain their enthusiasm. Randy was using his inhaler consistently each day after school. Moreover, he was hanging up his coat and putting away his books for the first time ever. And Dad was newly sympathetic and supportive of Mom in her efforts with their son. ■

Jeffrey Botman is a licensed psychologist, who specializes in strategic approaches to psychotherapy. While consulting and training throughout the New England area, he maintains his private practice in Cambridge, MA.

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Guest Commentary

Our bodies' byproducts are the topics of some new bestsellers

By Brian Hayden, PhD

Adam Smith argued years ago that what sells well can tell us a lot about people. So when there are best sellers, we should take notice. *Everyone Poops* and *The Gas We Pass* are enormous hits with people of all ages. To understand the success of these particular books, we first need to consider two earlier bestsellers.

Several years ago, two intriguing books were published. One, David Macaulay's *The Way Things Work*, described how a variety of gadgets, appliances and machines work. The other, Sherwin Nuland's *How We Die*, despite reminding us of the body's mortality, analyzed how the body works — and how it fails. It seems that understanding how mechanical things are put together and what physical mechanisms operate in the natural process of dying satisfy people's curiosity. If one considers the body and the machine as analogous, then it can be argued that these two books succeed because they resonate with people's fascination in how things — bodies and machines — work.

> *Everyone, from toddlers to grandparents, is fundamentally fascinated with the body. Flatulence, feces, scabs, snot, tears and urine are what our 'machine' produces as it functions.*

What causes that fascination? The personality theorist, George Kelly, suggested that psychologically everyone operates as a scientist. Each of us tries to give meaning to, and make sense out of, our experiences in the world in which we live. Some of us are good scientists; others are less successful. Understanding how things (bodies and machines) work is simply being a good common-sense scientist. These bestsellers provided a structure, or set of organizing concepts that help the reader understand both the body and the machine. Hundreds of thousands of people who bought these books became better scientists. Their world, thereafter, became more predictable, understandable and livable.

A big difference, however, exists between the body and the machine. Byproducts of the body attract everyone's interest; byproducts of the machine generally attract attention only if one of the by-products damages the environment or the ozone layer. *Everyone Poops* and *The Gas We Pass* are current bestsellers, and are soon to be followed by a book on scabs. These books about human byproducts are loved by both children and adults.

While a popular bumpersticker asserts that "[Poop] Happens," no one loses interest in what the human body produces. Everyone, from toddlers to grandparents, is fundamentally fascinated with the body. Flatulence, feces, scabs, snot, tears and urine are what our 'machine' produces as it functions. Knowing more about these by-products reveals a more predictable, understandable world.

Admittedly, not one of these categories of byproducts is without a 'yuck' factor. Fascination, however, persists. Perhaps the 'yuck' factor drives this fascination? But other 'yuck' items (for some it is spiders or roadkill or snakes) do not really intrigue most people. Might it be a matter of taboo? We might be interested in what is naughty, against the rules or forbidden. But most of us are not fascinated with defying a mother, stealing from the local grocery market or incest.

The fact that these two books about human byproducts became bestsellers demonstrates just how motivational people's fascination is. People buy a book describing a process about which they already indirectly know and which they experience almost daily. The fascination with the topic stems from more than just being 'yucky' or flirting with taboos.

Why the fascination with our byproducts? Each person's body produces byproducts. Each person's body is a component of the self. One creates, in other words, one's byproducts. Each of us quietly and unwittingly claims authorship to every byproduct, 'yucky' or not. None of the byproducts is a conscious effort, but the recognition of our agency in producing the byproduct intrigues and fascinates everyone's query "How did I do this?" This need to know has resulted in the bestseller *Everyone Poops*. Can the publication of *The Snot We Sniffle* or *As Tears Glide By* be far behind? ■

Brian Hayden, PhD, is a professor of psychology at Brown University and a clinical psychologist in private practice in Providence, RI. The My Body/Science Series is available from Kane/Miller Book Publishers, P.O. Box 310529, Brooklyn, NY 11231-0529; (718) 624-5120. The series includes *Everyone Poops*, *The Holes in My Nose*, *The Gas We Pass*, *Contemplating Your Belly Button* and *The Soles of Your Feet*.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Precocious reading skills may signal hyperlexia

By Phyllis Kupperman, MA

A three-year-old who is able to read? How wonderful! But what if that child can read but cannot communicate? What if that child has difficulty interacting with other children or has frequent tantrums? Speech and language pathologists, psychologists and special educators are seeing an unusual group of children with precocious reading abilities who also have developmental disabilities. These are children with hyperlexia.

Children in this group have a constellation of symptoms that includes reading skills that far exceed what would be expected of them based on their chronological age, accompanied by significant problems in language, learning and/or social skills. These children may have been diagnosed with Pervasive Developmental Disorders such as autism or Asperger's Disorder, behavioral disorders, language disorders and nonverbal learning disabilities.

Between three and four years of age, (hyperlexic) children teach themselves how to recognize words, sometimes before they have really learned to talk.

A small body of literature on the condition exists, dating from 1967, though these articles do not necessarily concur on a definition, symptomatology or etiology. At the Center for Speech and Language Disorders in Elmhurst, IL, speech and language pathologists and educational therapists say it is important not to disregard the precocious reading ability as mere rote learning, a "splinter" skill or a savant idiosyncrasy. For these pre-school children, reading can be a powerful tool for developing language, social and behavioral skills.

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This month's client handout
Supporting your child's social development

Emotionality and regulation predict social competence, problem behavior

By Nancy Eisenberg and Sandra Losoya

Research on emotion has moved center stage in psychology because of its important function in helping social scientists understand mental health and social behavior. In fact, social, clinical and developmental psychologists have increasingly linked individual differences in emotionality and its regulation to development of social functioning.

Much of what is known about the role individual differences in emotionality play in social functioning comes from research on temperament. M.K. Rothbart and J.E. Bates, in a chapter in the *Handbook of Child Psychology* (NY: John Wiley & Sons Inc., 1997, (800) 225-5945), say that aspects of temperament can affect whether people tend to display externalizing or internalizing problems (e.g., disruptive and acting-out behavior vs. anxiety, extreme shyness or withdrawal). For instance, young children who are highly inhibited are prone to anxiety disorders (especially phobias). Similarly, the tendency to display externalizing problems in adolescence has been linked with early temperamental irritability, lack of control and distractibility.

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Keep Your Eye On

... curiosity and attitudes.

Newest studies on young people and smoking say that attitudes, friends and family are the most important factors in influencing children to smoke. The *American Journal of Public Health*, the journal of the American Public Health Association, says that a study of 933 children in grades 3 through 6 found that curiosity was the main reason for trying cigarettes. However, first-time experimentation with cigarettes led to regular use depending upon the behavior of role models such as friends and parents. The young people were surveyed as part of the Bogalusa Heart Study. Fifteen percent of children surveyed in a southeastern Louisiana community had tried smoking. Forty percent of those first-time smokers tried it first with a family member, and 46 percent obtained the cigarette from a family member or from home. For more information, contact Jonathan Ellen, MD, Department of Pediatrics, University of California, San Francisco, at (415) 476-2184.

... designer drugs.

Current national and state surveys show a significant increase in the use of the designer drug "Ecstasy" among America's adolescents, according to *Pediatrics*, the journal of the American Academy of Pediatrics. The drug — MDMA — has mild hallucinogenic and stimulant properties, as well as a reputation for enhancing empathy and closeness to others, the journal article says. Ecstasy is widely available on college campuses, at dance halls and at all-night dance parties known as "raves." For more information, contact Richard Schwartz, MD, at (703) 938-2244 or Norman Miller, MD, at (312) 996-7712.

... foreign adoptees.

Young adoptees from the former Soviet Union and Eastern Europe do not have the severe neurological impairment their records indicate, but often do have developmental and growth delays, according to the *Journal of the American Medical Association (JAMA)*. For that reason, the authors suggest that these children at least temporarily be considered "special needs" children and that parents and physicians plan a period of intensive rehabilitation. The research, conducted by Lisa H. Albers, MD, MPH, of the Tufts-New England Medical Center in Boston, analyzed preadoptive medical reports of 47 children adopted from Eastern Europe and the former Soviet Union and compared these reports with evaluations after the children's arrival in the United States. Compared to children adopted from other regions of the world, these children were frequently older at the time of placement and had spent more time in orphanages. Researchers found that the children had one month of linear growth lag for every five months in an orphanage. Developmental delays in the children included gross motor (70 percent); fine motor (82 percent); language (59 percent); and social-emotional (53 percent). *(JAMA, 278:922-924, 1997)*

Hyperlexia

from page 1

Children with hyperlexia are able to decode the printed word at a very early age. This skill is not taught by parents. Parents are amazed at the child's ability — usually between 18 and 24 months of age — to name letters and numbers. Between three and four years of age, the children teach themselves how to recognize words, sometimes before they have really learned to talk. Some children learn to read words by sight, while others are able to phonetically decode any word they see. Some children are able to spell precociously as well. One child, when given an alphabet puzzle for his third birthday, looked at it for a few minutes and then rearranged the letters to spell chipmunk. He felt compelled to find a word that did not use duplicate letters.

The most common disorder evidenced by children with hyperlexia is in language learning. Of those children who talk (some children with hyperlexia are nonverbal), most show the following language learning characteristics:

Early speech and language attempts are echolalic (both immediate and delayed). These children memorize language patterns such as "ready, set, go" or dialogues from videos. They have difficulty processing the language they hear, and some of their early speech attempts are patterned jargon in which the intonation of the phrase is discerned, but their reproduction of the words is not accurate. They may attempt to use the patterns in semi-appropriate ways. One boy came out of the bathroom and announced, "Honey, I'm home!"

Comprehension of language is based on patterns because these children have difficulty figuring out word units in the language. Their method of language acquisition is similar to how an adult might learn a second language by listening to tapes of foreign phrases. If one word in the phrase is changed, the child may not understand it at all. Consider the confusion created if such a child was told, "Get all the black crayons," and then was told, "Get all *except* the black crayons."

Yet children with hyperlexia seem to have visual recognition of "wordness" that may be unrelated to the verbal signal. They may be able to comprehend the written word while not comprehending the same word when presented verbally. In most of these children, however, the comprehension of written language mirrors their comprehension of verbal language, and they usually can decode more than they can comprehend. The written word supports their processing of verbal language because it is permanent while verbal language is fleeting.

Intensive speech and language therapy and early intervention programs are crucial in helping children with hyperlexia.

Good auditory memory for rotely learned songs, the alphabet and numbers accompanies their good visual memory, but they may not comprehend what they have memorized. Some children have memorized entire episodes of *Thomas the Tank Engine*, complete with British accents.

As these children gain more language, marked abnormalities in form or content — including stereotyped and repetitive speech, pronoun reversals and idiosyncratic use of words or phrases — become increasingly frequent. Such a language learning style results in difficulties in using language flexibly for thinking. Children with hyperlexia tend to use language quite literally and concretely and must be taught specifically to comprehend idioms and metaphors. One child was quite confused when he was told to "keep his eye on the pizza."

Despite the development of adequate speech, children with hyperlexia have difficulty with social use of language. They miss the nuances of meaning, and they have trouble initiating or sustaining a conversation.

Nonverbal learning disabilities

Another constellation of symptoms, some of which may be related to deficits in language comprehension, also are frequent in this group of children. These are associated with social relatedness, pragmatic and behavioral issues and/or nonverbal learning disabilities. Many of these children have symptoms commonly associated with Pervasive Developmental Disorders. These include noncompliance, rituals, difficulty with transitions, tantrums, sensory sensitiveness, anxieties, usual fears, difficulty with peer group interactions and impaired ability to sustain friendships.

As language comprehension and expression improve, these behavioral symptoms often subside. Indeed, some children with hyperlexia may look quite autistic when they are two to three years old, but they tend to show less severe symptoms when their language skills improve.

Hyperlexia exists on a continuum with other developmental disorders. It is important to identify children with hyperlexia across diagnostic categories in order to understand the common way in which they learn, so that effective therapeutic and educational programs can be devised for children who have the condition. As their caregivers learn strategies to help them understand what is wanted or expected, these children become less anxious, more compliant, more related and more able to learn.

How to help

Intensive speech and language therapy and early intervention programs are crucial in helping children with hyperlexia. A hyperlexic child's reading skills should be used as the primary means of helping her develop language, and she should be specifically taught reading comprehension. It is also important to teach appropriate social skills in the home and school settings. Parents, teachers and other professionals should work together to develop programs to help each child reach his or her potential. The Center for Speech and Language Disorders has developed the following list of strategies for intervention:

- Use written and visual models.
- Use patterned language and fill-in-the-blank sentence forms.
- Use verbal imitation skills to script conversation.
- Generate written schedules and lists of rules to follow.
- Plan ahead by preparing the child for transitions and changes in routines in writing.
- Use examples, not explanations.
- Use rote learning.
- Base activities on the interests of the child; for example, trains or *Wheel of Fortune*.
- Use a positive reward system.
- Include the family in planning and participating in intervention.

Children with hyperlexia can be delightful and challenging individuals. It is hoped that by understanding their unique combination of symptoms, and by using their strengths in visual processing and reading to help overcome their weaknesses, effective therapeutic and educational programs can be devised. ■

Phyllis Kupperman, co-director of the Center for Speech and Language Disorders, Elmhurst, IL, is a speech and language pathologist specializing in language learning in higher-functioning children with Pervasive Developmental Disorders and hyperlexia. Further information on hyperlexia can be obtained from the Center for Speech and Language Disorders at (630) 530-8551, or the American Hyperlexia Association at (630) 415-2212; www.hyperlexia.org.

Emotionality

from page 1

We believe that individual differences in emotionality and regulatory capacities influence whether people become emotionally overaroused in evocative contexts and, therefore, determine the quality of their social behavior.

Consistent with this view, we have been able to use individual differences in nonclinical schoolchildren's emotionality and regulation to predict, to some degree, their problem behaviors and social competence.

For example, in a study of children in kindergarten to third grade, teachers' and parents' reports of differences in children's behavioral regulation (ability to control their actions) and intensity and frequency of negative emotionality were directly related to their reports about schoolchildren's externalizing behavior problems.

Children with more externalizing behaviors were reported to be high in intensity and frequency of negative emotion and low in behavioral regulation.

These associations usually were found even when different reporters — teachers, mothers or fathers — provided information on children's problem behavior and emotionality or regulation. Moreover, the ability to predict externalizing problem behaviors generally was stronger when individual differences in both emotionality and regulation were used as predictors than when either was used as the sole predictor.

Emotion-relevant regulation

Individual differences in emotion-relevant regulation also have been associated with positive aspects of social functioning, such as social competence and socially appropriate behavior. For example, we found that four- to six-year-old boys whom teachers rated as able to control their attention through shifting and focusing of attention — a type of emotion regulation — were relatively high in sociometric status as rated by peers, and in socially appropriate behavior as assessed by independent observers. Attentional control also was correlated with boys' use of nonabusive language to deal with anger and frustration in real-life social interactions.

Moreover, teachers' reports of attentional and behavior regula-

Nobody likes me

The way you react to your child's problems can enhance or undermine his or her relationships with other kids.

You won't be surprised to hear that sociable children have better relationships with their peers. It makes common sense. But the point is an important one: Your child's personality may have a lot more to do with his or her social adjustment than you think.

A study found that intense, moody or emotionally negative children are less popular with their peers. According to the researchers, children's temperamental characteristics may elicit similar responses from their schoolmates. In other words, hostile children may be met with hostility, and withdrawn children may be left to eat alone in the cafeteria.

Good social functioning is more than just having someone to ride bikes with. Another study showed that kids' relationships with their classmates as early as kindergarten affected how they did in school. "Early peer rejection predicted less favorable school attitudes, increasing school avoidance and lower levels of performance over the course of kindergarten," writes Gary W. Ladd, PhD, a professor of educational psychology at the University of Illinois at Urbana-Champaign. "Early school adjustment is partly a function of the attributes and experiences that children 'bring' to new classrooms and partly a function of the types of relationships children experience as they cope with these settings." If your daughter is very shy, she may have trouble making friends. Or if your son is quick to anger and aggression, the other kids may avoid him. As a parent, you may feel bad or helpless, or even tempted to transfer the child to another school. But there are things you can do to support your child's social development.

As with any serious problem, it's best to first rule out physical causes. Pay a visit to the pediatrician. Can the child hear what's being said? Does she need glasses? Don't overlook mental health. Social withdrawal can be a symptom of depression, and children get depressed too.

Parents can help their kids learn to control their emotions and use more constructive ways of coping with stressors, according to Nancy Eisenberg, PhD, a psychology professor at Arizona State University. Dr. Eisenberg and her colleagues conducted a study of 148 elementary school children and examined how their parents reacted to their children's negative emotions. Children whose mothers focused on helping the child problem-solve tended to do well socially. For example, when a kid breaks his or her bike, a problem-focused reaction would be to help the child figure out how to get the bike fixed.

Two things that don't work, according to Dr. Eisenberg's research, are punishing the child or minimizing the child's problem. The children of parents who reacted this way tended to be less socially competent and to cope with problems by avoiding things.

One of the study's most interesting findings was that children with supportive mothers tended to rate their own social skills higher than did other kids. It may be that children with good social skills tend to elicit positive reactions from their parents — as from their peers. But it's also possible, says Dr. Eisenberg, that parents who react in a support-

... *Continued on next page*

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ive, problem-focused way encourage positive self-perceptions.

The study shows a correlation between a parenting style and good social functioning, which doesn't necessarily mean one leads to the other. But it couldn't hurt to try a new approach.

"By responding in a positive, constructive manner to their children, parents may implicitly communicate that they believe their children's behavior is socially appropriate," Eisenberg and her colleagues say. "If this is true, parents' emotion-related reactions may influence children's self-esteem." ■

What about Dad?

A study last year showed that a mother's parenting style could help or hinder her child's social adjustment. But these findings did not hold up for fathers. Although fathers' minimizing reactions were associated with lower ratings of children's popularity and social skills, the overall findings were weak. The researchers aren't sure why there should be such a big difference between mothers and fathers. It may be that mothers are more likely to discuss feelings with their children, or that children have different expectations of their mothers' and fathers' parenting styles. If children expect their fathers to dismiss their concerns, then it might not bother them when they do.

The Brown University **Child and Adolescent Behavior Letter**

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tion were associated with children's social competence at school, two and sometimes four years later.

In other samples, we have found associations between sympathy or prosocial behavior and emotionality and attentional or behavioral regulation. For example, children prone to experience other-oriented sympathy tended to be viewed by parents and teachers as being relatively well-regulated, and, particularly in the case of boys, as being low in intensity and frequency of negative emotionality. To some degree, early differences among children in their regulation and negative emotionality predicted sympathy two or four years later.

The relations between regulation and quality of social functioning appear to be relatively robust. For instance, in several studies there were moderately strong correlations — from .30 to .65 across reporters or time — between measures of attentional or behavioral regulation (particularly the latter) and measures of social competence and problem behavior. However, findings pertaining to regulation sometimes have been stronger for boys, perhaps because girls tend to score higher on measures of regulation than do boys and, consequently, girls may be above the minimal threshold of regulation needed for competent social functioning.

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Additive and moderating effects

The relations of dispositional emotionality or regulation to quality of social functioning often are additive in their effects and sometimes moderate one another (i.e., statistically interact in predicting outcomes). That is, statistical interaction of individual differences in emotionality and regulation sometimes predicts additional variance in social functioning above and beyond main effects and additive effects. Often the pattern has been that regulation is more important for predicting social competence and low problem behavior for children who are high in emotional intensity. For example, we have found that social competence generally is higher for well-regulated children, but that this relation is stronger for children who are prone to experience emotions intensely.

In one study, this moderating effect held at early- and mid-elementary school age when predicting children's socially appropriate behavior. Moreover, at ages six through eight, children rated as high in sympathy by teachers were those viewed by teachers as both prone to intense emotions (either positive or negative) and well-regulated. Children who were emotionally intense but unregulated were not sympathetic, perhaps because their vicarious emotion was experienced as overarousing and aversive.

Similarly, the relation of regulation to externalizing problem behavior appears to be moderated by individual differences in children's negative emotionality. In the aforementioned study of children in kindergarten to third grade, teachers' reports of regulation predicted teacher- or parent-reported problem behavior for the total sample; however, prediction was strongest for children high in negative emotionality. Thus, regulation was most important for predicting the problem behavior of children prone to negative emotion.

In summary, it is clear that emotion-relevant regulatory processes are related to quality of social functioning, and that individual differences in these processes, and the factors that influence them, are likely to play an increasing role in the study of the quality of children's social functioning. Of course, dispositional emotionality and regulation can reflect environmental as well as constitutional factors. For example, there is evidence that parental punitive or minimizing reactions to children's negative emotions (e.g., anxiety, sadness) correlate with lower-quality social functioning in children. It is likely that socializers help to shape children's emotion-related expectations and attributions, as well as children's abilities to regulate emotion, and thereby influence children's tendencies toward emotional overarousal and behavioral dysregulation. However, research on socializers' contributions to children's dispositional emotion-related reactivity and regulation is relatively scarce and sorely needed. ■

Nancy Eisenberg is Regent's Professor of Psychology at Arizona State University's main campus in Tempe.

Sandra Losoya is a research associate in the Arizona State University Department of Psychology.

For more information, Eisenberg and Losoya can be reached at Arizona State University, Department of Psychology, Main Campus, P.O. Box 871104, Tempe, AZ 85287-1104.

What's New in Research

Abuse history influences HIV risk for adolescents

Adolescent psychiatric inpatients, particularly those with a history of sexual abuse, are at risk for HIV infection because they frequently engage in high-risk behavior when making decisions about sexual activity, according to a recent study.

The study measured HIV-related knowledge, attitudes and behaviors reported by 100 primarily white youths ages 12 to 17 who were admitted to a psychiatric hospital for children and adolescents experiencing mood or conduct disorders. Researchers looked at factors that may contribute to HIV-related attitudes and behavior of sexually abused adolescents with a psychiatric disorder. Communication skills, assertiveness and social competency were measured through videotaped role-plays. Researchers identified a number of high-risk behaviors among the 71 percent of those studied who reported that they were sexually active: unprotected intercourse (67 percent); multiple partners (27 percent); alcohol and drug use (25 percent); sharing cutting instruments with others engaged in self-cutting behavior (22 percent).

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Thirty-eight percent of the sample reported having a history of sexual abuse, most of them female (47 percent, compared to males, 24 percent). This group is particularly at risk for HIV infection because many sexually abused adolescents have feelings of low self-esteem, fear of rejection, mistrust, helplessness and powerlessness, which feed into the leading cause of exposure for HIV in teens: failure to set limits in sexual encounters.

The authors note that direct discussion of these issues in a therapy setting does not create anxiety among sexually abused patients but, rather, helps "empower" them to take precautions in an intimate relationship.

"Influence of sexual abuse on HIV-related attitudes and behaviors in adolescent psychiatric inpatients," Larry K. Brown, MD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry* 36(3):316-322, 1997. For reprints, contact Dr. Brown, Child and Family Psychiatry, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903.

Male homosexuality linked to risk of eating disorders

A study of men with eating disorders has found that homosexuality and bisexuality appear to be specific risk factors for males who develop bulimia.

"For those who believe that cultural pressures toward thinness cause eating disorders, homosexuality can be seen as a risk factor that puts males in a subcultural system that places the same premium on appearance in men as the larger culture places on women," say the researchers.

The study attempted to understand the etiology, clinical characteristics and prognosis of eating disorders in men by reviewing records of all males treated for eating disorders at Massachusetts General Hospital between January 1, 1980 and December 31, 1994. Of the 135 men identified with eating disorders, 46 percent were bulimic; 30 percent were anorexic and 43 percent met criteria for other unclassified eating disorders.

The researchers found marked differences in sexual orientation by diagnostic group: 42 percent of the male bulimic patients were either homosexual or bisexual; 58 percent of the anorexic males were identified as asexual. The study also found that there was a high rate of comorbid major depression, substance abuse, anxiety disorders and personality disorders, as discussed in other studies of eating disorders in men and women.

While the age of onset was found to be late adolescence or early adulthood with no significant difference between diagnostic groups, the time between onset and treatment was longer for bulimic men than for anorexic men.

"In general, bulimic men in our study group felt ashamed of having a stereotypically 'female disorder,' which may explain their atypically long treatment delay," the authors wrote.

"Eating disorders in males: a report on 135 patients," Daniel J. Carlat, MD, et al., *American Journal of Psychiatry* 154(8):1127-1131, 1997. For reprints, contact Dr. Carlat, Department of Psychiatry, Anna Jaques Hospital, 25 Highland Ave., Newburyport, MA 01950.

Childhood neglect may be linked to BPD

Although some research has suggested that sexual abuse is the main etiological factor in the development of borderline personality disorder (BPD), recent studies suggest that neglect and the opportunity for abuse that thrives in an atmosphere of neglect also contribute.

Researchers at McLean Hospital found that neglect can take the form of emotional withdrawal from the child, denial of the child's thoughts and feelings, inconsistent treatment of the child and failure to provide protection for the child.

Four predictors of BPD identified in this study are: female gender, sexual abuse by a male non-caretaker, emotional denial by a male caretaker and inconsistent treatment by a female caretaker.

The study used multivariate analysis of 467 inpatients and a more inclusive list of childhood experiences than in previous research in attempting to clarify the role of many pathological childhood experiences in borderline patients. Analysis was based on semistructured interviews that were conducted by people blind to the diagnosis.

Results show consistently high self-reporting of abuse and neglect. Ninety-one percent of the BPD patients said they had been abused and 92 percent said they had been neglected before the age of 18.

While the research does not discount the role of sexual abuse in these patients, the authors of the study conclude that sexual abuse "is neither necessary nor sufficient for the development of BPD." Researchers observed that the abuse "seems to be embedded in an atmosphere of general chaos and neglect by both parents" and that sexual abuse is more likely to occur in that type of atmosphere.

"Reported pathological childhood experiences associated with the development of borderline personality disorder." Mary C. Zanarini, EdD, et al., *American Journal of Psychiatry* 154(8):1101-1105, 1997. For reprints, contact Dr. Zanarini, McLean Hospital, 115 Mill St., Belmont, MA 02178.

Recommended Reading

ALCOHOL MISUSE: A EUROPEAN PERSPECTIVE — *Timothy J. Peters (Ed.) International Publishers Distributors, 1996, 200 pages, $68 (hard), $27 (soft); fax +44-118-956-8211.*

Although not cast as such, this is an excellent handbook, providing reviews of recent data on the causes and consequences of excessive alcohol intake anywhere, not only in Europe. While two of the 12 chapters relate to European issues (Trends in alcohol consumption in Europe and Alcohol-related adverse social consequences within the European Union), the other 10 chapters deal with "universals": Racial/ethnic and gender differences in alcohol use and misuse, alcohol and nutrition, alcohol and the liver, HIV and alcohol abuse, neuropathology and imaging studies, alcohol and the pancreas, etc. The book is full of interesting and edifying information. It would be better for handbook use if there were a full index; for example, there is no way to easily locate all the pages on the liver without looking at each individually-authored chapter and the headings in those chapters.

Commentary

from page 8

average" effect is extremely robust across characteristics, no matter how desirable or controllable they are. Not surprisingly then, a recent classroom exercise at Brown University showed that all students expected to do better than most of their classmates on the midterm exam. Another method of self-enhancement is to overestimate the desirability of one's own traits. People who concede to be selfish, for example, consider selfishness to be less undesirable than people who claim not to be selfish. Again, this bias does not depend on the social desirability of the trait. Kind people consider kindness to be more desirable than unkind people do. Significantly, individual differences in self-enhancement are related in differences in self-esteem and narcissism. High self-esteemers and narcissists are most likely to overestimate their own accomplishments and overvalue their own traits. These findings question a uniformly positive interpretation of self-esteem. Only further research can answer the question of whether increases in self-esteem can come without the attendant cost of increasing narcissism and self-enhancement.

Understandably, the quest for high self-esteem will remain a priority for many of those who do not have it. For better or for worse, however, this goal is already realized for most people. Consistent with the self-enhancement motive, an informal survey revealed that most participants not only reported high self-esteem, but also believed that their own self-esteem was higher than that of most other members of the same group. This is not surprising in a culture in which the happy fool is close to becoming the paragon of mental health. ■

Joachim Krueger is an associate professor of psychology and human development at Brown University, Providence, RI.

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Commentary

Self-esteem and its discontents

By Joachim Krueger, PhD

High self-esteem is widely regarded as a desirable quality in children and adolescents, on a par with intelligence, knowledge, achievement or moral goodness. Its attainment and maintenance have become a primary goal for many people. Profitable industries promise improvements in self-esteem, and the public response has been enthusiastic. Who would not want to feel good about themselves? For these reasons, criticism of the concept of self-esteem is seldom welcomed.

Besides its intrinsic appeal, high self-esteem is often honored as the root cause of many desirable behaviors. By the same logic, socially troublesome behaviors are often explained as outcomes of low self-esteem. The California Task Force, established in 1986, conducted an extensive review of relevant research findings. Unexpectedly, the findings failed to demonstrate any causal relevance of self-esteem. Worse still, self-esteem had little value as a statistical predictor of problem behaviors such as child abuse, academic performance, unwanted teenage pregnancy, crime and violence. Nevertheless, the Task Force recommended that money be appropriated to develop methods for raising levels of self-esteem!

In pursuing the prospect of enhancing self-esteem, the Task Force staked its hope on an appealing but improbable pair of ideas. One was that empirical research had overlooked some beneficial effects of high self-esteem. The other was that even if high self-esteem did not produce desirable outcomes, it would not produce undesirable outcomes either. Many research psychologists have since disputed both of these ideas. Rather than denigrating high self-esteem, these critics question its relevance as a source of socially significant behaviors.

Complex social behaviors have many causes. If society's goal is to increase desirable behavior and decrease the prevalence of undesirable behavior, intervention should focus on factors that have been shown to be effective. Giving students incentives to study harder, for example, is more likely to lift their grades than making them feel good about themselves. Educating teenagers about contraception is more likely to reduce the number of unwanted pregnancies than raising global feelings of self-worth. To the extent that there are relationships between self-esteem and behavior, research indicates that self-esteem is the outcome rather than the cause. High self-esteem follows successful and goal-directed efforts; low self-esteem follows avoidable failures.

Why does the public's fascination with high self-esteem continue despite the sobering research evidence? One reason may lie in the fact that the concept of self-esteem embodies a deeply held cultural value. A society that stresses individualism and the pursuit of happiness sees self-esteeming individuals as being fulfilled or "actualized." The flip side of this coin is that social problems are understood as individual problems, caused by factors within the person and cured by interventions operating on the person. Such individualized values are far from universal. Many cultures emphasize the individual self less than North American culture does. It seems safe to assume that good feelings are universally appreciated. Strikingly, however, few cultures share the notion that one could feel or should feel good *about oneself*. Indeed, if the language does not supply the tools to express this idea, it is doubtful that the idea has much psychological presence. Many Romance and Germanic languages, for example, only permit expressions of reflexive feelings (je me sens, me siento, ich fühle mich). This grammatical construction makes a reference to the self, but the self remains the feeling agent and not the felt object. Inasmuch as cultural and linguistic environments shape the representation of behavioral problems and their causes, they guide and constrain the search for remedies.

In the prevalent cultural representation, high self-esteem is unambiguously good. How could raising it be hurtful? Recent findings suggest that high self-esteem can indeed hurt. People with high self-esteem also tend to be narcissistic and self-enhancing. Narcissists are grandiose and feel that the world owes them respect and that they deserve special treatment. Narcissistically inflated self-esteem is defensive and hostile. The trouble is that self-esteem boosters rarely distinguish between benign and antisocial self-esteem. Self-enhancers see themselves in a more favorable light than they see others and describe themselves more favorably than others describe them. In his book *House of Cards*, Robyn Dawes reported that most students believed they would be less likely than the average person to become sick. This "better-than-

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The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special Issue: Child care

Research on day care should spur a new look at old ideas

By Sandra Scarr, Ph.D.

American child-rearing practices are undergoing a sea change. As increasing numbers of mothers rejoin the labor force earlier in their children's lives, day care has become a standard experience for infants and young children. Many experts worry that children are not getting sufficient attention from their parents to develop solid foundations of intelligence and mental health.

Indeed, we should worry about the small minority of children whose caregivers are truly abusing or neglecting them. But much of the experts' concern — which unnecessarily alarms working parents — is caused by their reliance on past assumptions about children's development that no longer match reality. Experts should re-examine their theories in light of research showing that children in day care develop as normally and as quickly as children who stay home with their mothers.

Can it be true that specific early experiences must be programmed to ensure that babies will become normal adults?

Unwarranted fears

Renewed interest in early brain development is one symptom of a cultural fear about changes in parenting. Are parents giving infants and toddlers enough of the right kind of stimulation to develop proper neuronal connections?

The recent White House Conference on Early Childhood Development and Learning and articles in

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Vol. 13, No. 12 December 1997

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Bilingual preschoolers learn reading and writing skills better than monolingual children.
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Toddlers subjected to "dirty looks" from Mom have increased likelihood of learning problems later.
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Murderers' brains show many metabolic abnormalities.
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Guest Commentary: Skeptics refuse to accept child care research.
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This month's client handout
Finding the right day care program for your child.

To care or not to care?

By Lewis P. Lipsitt, Ph.D., Editor

Should we have child care or not? And of what sort?

Aren't those strange questions? Of course we have, have had and *will* have child care, so long as parents have children.

The amount of angst that has been generated over issues surrounding day care for children in this country is amazing. The issues usually have to do with out-of-home care, although this is not always the type of care that is used, or that we should be concerned solely about. After all, grandparents, aunts and even dads sometimes take on the care of the child in the home while the parent or one of the parents is working outside of the home. And mothers have been doing it forever.

Citizens of other countries where day care for children of working parents has become a fine art, as in France and the Scandinavian countries, are bemused by the furor that the subject of child care raises in America. They know that it is possible to have safe and creative child care for children outside of the home. They know that for some parents, either because of economic conditions or because both parents are skilled in some work that they love, child care is not just an option but a modern-

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The Brown University **Child and Adolescent Behavior Letter**

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Keep Your Eye On

... home drug testing.

Only six weeks after the nationwide introduction of its Parent's Alert Home Drug Test Service, ChemTrak Inc. announced that it has shipped more than 10,000 units to more than 4,500 drug stores and expects to ship a total of 15,000 units by the end of the year.

The home test was designed to form a base for ongoing family drug prevention. According to president and company CEO Edward F. Covell, Parent's Alert provides accurate testing for the eight drugs most commonly abused by teens. Each kit contains a question-and-answer booklet and a number to call for information and counseling.

"Once a parent has decided to proceed with drug testing," Covell said, "our test service enables them to receive confidential results by telephone."

For more information, contact Donald V. Fluken at ChemTrak Inc., Sunnyvale, Calif., (408) 773-8156.

... favorable trends in children's health.

The infant mortality rate was at an all-time low for children born in the United States in 1996, and their life expectancy was at an all-time high, according to an annual summary of statistics published in the December issue of *Pediatrics*. The preliminary infant mortality rate for 1996 nationwide was 7.2 per 1,000 live births, 5 percent lower than the 1995 rate of 7.6. The life expectancy for a child born in 1996 was a record high of 76.1 years.

A decline in homicide and suicide — two of the most common causes of death among children — was noted between 1995 and 1996.

Although the percentage of low birthweight infants rose to 7.4 percent in 1996 — the highest level reported since 1975 — the traditional risk factors did not appear to be to blame. Smoking during pregnancy was down and early prenatal care rates were up. Older mothers giving birth and the rise of multiple births may have accounted for the higher percentage.

The summary also noted that teenage childbearing in all ethnic groups fell for the fifth consecutive year, with 1996 marking the first substantial decline for Latin youths since data for this group have been available. For more information, contact Bernard Guyer, M.D., at (410) 955-3384.

... single parenting.

Results from a new nationwide study cast doubt on the common belief that children in single-parent households are better off living with their same-sex parent. Doug Downey, co-author of the study, said the research should persuade judges involved in child custody cases that there is no inherent advantage for girls to be placed with their mothers or boys with their fathers.

An examination of data from three national surveys involv-

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ing 11,018 people revealed only one survey in which children who lived with their same-sex parent fared better than others. Moreover, in one of the surveys, children were less likely to become a parent (or to be expecting a child) if they lived with an opposite-sex parent. Although same-sex role models are important, Downey says children can find appropriate mentors in settings outside the immediate household. Downey can be reached at (614) 292-1352; e-mail Downey.32@osu.edu

... telltale hearts.

A toddler's low resting heart rate can reveal something far more sinister than poor physical conditioning, according to a recent study published in the October *Journal of the American Academy of Child and Adolescent Psychiatry*. "A drop of just six beats a minute can point to a three-year-old's propensity for aggressive behavior and violent crime at a later age," said Adrian Raine, Ph.D., lead author of the study. He emphasizes, however, that one cannot use heart rate in and of itself to predict which toddlers are likely to become aggressively antisocial adults.

Nobody knows the precise role that resting heart rates play in predisposing a child to crime, but low rates have been linked to fearlessness and thrill-seeking behavior. Raine suggests that if low resting heart rate is a risk factor for criminality, high rates could act as a protective mechanism.

... interactive kiosks.

A new national program designed to disseminate timely information on missing children to the general public via multimedia technology has already proved successful.

The *Deliver Me Home* kiosk program is an effort developed by the National Center for Missing and Exploited Children (NMEC) that has been endorsed by the American Academy of Pediatrics (AAP). The NMEC plans to install 400 information kiosks in busy public areas such as airports, train and bus terminals and shopping malls. There are currently 42 kiosks nationwide.

Each kiosk has a brief video program and alerts on currently missing children plus bilingual safety tips. A hotline phone is included with each kiosk so that child sightings can be reported immediately to the NMEC. With the capability to update and monitor the kiosk at any location in the country, information on newly reported cases can be sent via modem regionally or nationally.

To date, the kiosks have recorded more than 450,000 hits. The first confirmed recovery due to the *Deliver Me Home* kiosk occurred in Philadelphia on July 29, 1997, only two weeks after the kiosk had been unveiled at Franklin Mills Mall in Philadelphia.

To find the kiosk in your area, contact Pegi Shriver at the National Center for Missing and Exploited Children, at (703) 516-6117.

Resources

Resources available for disabled children

The *Children's Disability Bookshop Catalog* — a shop-by-mail catalog listing of hard-to-find titles covering a wide range of health topics for children — has just been published.

The catalog includes books about general medical topics, allergy, asthma, autism, cerebral palsy, Tourette syndrome, deafness, Down's syndrome, special education, learning disabilities, financial aid, mental illness, learning games, and more.

To receive the catalog, send $4 for postage and handling to: The Disability Bookshop, P.O. Box 129, Vancouver, WA 98666-0129. For more information, call (360) 694-2462. Audiocassette catalogs are available for $5.

Over the past few months, we provided two free special bonus reports to subscribers:

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— Fraser A. Lang, Publisher

Conference on adolescence set for Feb.

The Society for Research on Adolescence will hold its 1998 Biennial Conference at the Hotel del Coronado in San Diego, Feb. 26 to March 1, 1998.

To register for the meeting, contact Darwin Eakins and Belinda Conrad, c/o EC Enterprises Inc., P.O. Box 1793, 835 Louisiana St., Lawrence, KS 66044-8793.

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What's New in Research

Second language aids reading, writing

Bilingual preschoolers can read sooner than those who speak one language because they are able to recognize symbolic relations between letters/characters and sounds without having visual objects, according to the latest research on reading.

The study's researcher says there are definite advantages to being bilingual when children are learning to read, providing they are exposed to stories and literacy in both languages.

During the study, 137 bilingual (French-English speaking and Chinese-English speaking) and monolingual (English-speaking) four- and five-year-olds were tested for their concept of how print refers to language. They were given two word tests to assess their understanding of the symbolic function of letters.

In the first test, the children were given a card with a word printed on it that was placed under a picture of the named object. When asked what the word was when it was moved to another picture, bilingual children scored twice as high as monolingual children.

The second test asked the children to judge a word's length when the object size was the same and when it conflicted with the word size. When the word was long and the picture was big, no difference was found between the monolingual and bilingual groups. However, the Chinese-English speaking children scored higher when the word length conflicted with object size.

The author concluded that by age four, bilingual children progress more than monolingual children in understanding general properties of the symbolic function of written language. By five, they are more advanced than monolinguals and bilinguals who have learned only one writing system.

"Effects of bilingualism and biliteracy on children's emerging concepts of print." Ellen Bialystok, Ph.D., *Developmental Psychology* 33(3):429-440, 1997. For reprints, contact Dr. Bialystok at the Department of Psychology, York University, 4700 Keele St., North York, Ontario M3J 1P3, Canada.

Fellowship available

The Irving B. Harris Graduate School of Public Policy Studies at the University of Chicago is seeking candidates for a one-year A.M. program providing expertise in early childhood development and skill in policy research and analysis. Full tuition and $10,000 stipend are awarded; there are no research requirements. Fellowship period is one academic year, beginning September 1998. Applicants must hold a degree in childhood development or a related field. Apply by Jan. 15. Contact Nancy O'Connor, Dean of Students, 1155 East 60th St., Chicago, IL 60637; (773) 834-0136.

Mom's 'dirty looks' may hinder problem solving

It appears that mother's disapproving looks may have more than a momentary sting, according to a recent longitudinal study of child temperament and observed maternal responses.

The study looked at maternal ratings of child temperament and observed maternal behaviors (comments, smiling or harsh looks) at home when children were 18 months old. Both variables were then examined as predictors of behavior with toddlers at 30 months. Disapproving behavior by the mother increased the likelihood of the child developing learning problems at age 5. Also, those children tended to have lower verbal and math scores on IQ tests.

Maternal behaviors were found to relate to the child's performance on the Wechler Preschool and Primary Scale of Intelligence at age 5, and lack of maternal cognitive assistance related to learning problems described by kindergarten teachers at age 5.

The study contributes to the growing interest among researchers in examining social influences on cognitive development.

"Mother-child problem solving: continuity through the early years." Beverly I. Fagot, Ph.D., and Mary Gauvain, Ph.D., *Developmental Psychology* 33(3):480-488, 1997. For reprints, contact Dr. Fagot, Oregon Social Learning Center, 207 E. Fifth Ave., Suite 202, Eugene, OR 97401, or via e-mail, bfagot@oregon.uoregon.edu.

Brain damage linked to violent crime

Some murderers show significant metabolic abnormalities in as many as six areas of the brain, several of which can suffer damage during gestation or birth, according to a new study. However, according to a second study, the added complication of specific forms of maternal rejection is needed to predispose these perinatally brain-injured youths to violence.

In the first study, researchers used positron emission tomography (PET) to scan the brains of 41 murderers who had pleaded not guilty by reason of insanity. They also scanned the brains of 41 control subjects matched for known mental disorders, age and gender.

Finding the right day care program for your child

Working parents wonder if they're doing the right thing when they put their child in day care. The experts have conflicting advice, and out-of-home child care has only begun to be researched extensively in the last few years.

The good news is that kids in quality day care programs seem to do just fine. The key word here is "quality." In many communities, it's hard enough to find child care programs with openings, particularly good ones.

It's worth the effort, says child care researcher Deborah Lowe Vandell, Ph.D. "The quality of the programs we've looked at is related to success — both social and academic," says Dr. Vandell, a professor of educational psychology at the University of Wisconsin.

Here are some recommendations for finding a good child care program.

- **Pay a visit.**

  Spend an hour or two at the program, preferably over two days ("but one day's better than none," Dr. Vandell says). Day care programs are busy places and may overwhelm an uninitiated visitor. Dr. Vandell suggests picking out one child and following (monitoring) him or her unobtrusively for 15 minutes, then choosing another child for the next 15 minutes. "Look at what the caregivers are doing, look at what's going on, look at that child's interactions with staff and peers, look at what activities they do," she says. Take your child with you on one of the visits, and later ask for his or her opinion.

- **Consider your child's age.**

  Younger children do better in programs that are highly structured. But around third or fourth grade, kids prefer to pursue individual interests, like drama or sports. "When early middle-school children are working on the yearbook, they're not looking at it as child care," Dr. Vandell says. "It is child care, but it's a club-based kind of approach that allows for individual autonomy." If you're looking for day care for a child in third grade or up, what you're really looking for is after-school enrichment activities. "After-school time could provide really important experiences," Dr. Vandell says. "There are some wonderful things that could happen."

- **Find out what the caregivers are like.**

  How the staff interacts with the children at the center is critical. Look for caregivers who are warm and sensitive to the children's needs, Dr. Vandell says. She

... *Continued on next page*

has found that children who have more positive interactions with their caregivers do better in school than those whose caregivers are negative or punitive. Find out how many kids are enrolled in the program, and how many caregivers there are. Infants and toddlers should be in small programs with a lot of attention from the staff. But while the ratio of children to caregivers can get bigger as the child gets older, the larger the number of children, the more negative interactions there are, according to Dr. Vandell's research. The program staff also should have received special training in the age group of the children they're taking care of.

- **Find out where the child's friends go.**

  Kids would much rather be in a program with their friends. Talk to other parents and see if you can keep them together.

- **Listen to your child.**

  What children say about their child care program is consistent with the observations of professionals, Dr. Vandell has found in her research. If your child is complaining about the day care staff or the program, take the complaints seriously. "Children have a lot of knowledge and understanding," Dr. Vandell says.

The Brown University Child and Adolescent Behavior Letter

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Mental disorders among the subjects included schizophrenia, organic brain damage and a history of head injury.

On average, the murderers showed significantly lower rates of glucose uptake (directly related to cell activity) in three areas of the brain — the prefrontal cortex, the corpus callosum and the posterior parietal cortex. When the researchers compared the brain's two hemispheres for glucose uptake rates, they found that murderers consistently showed weaker activity in the left — the more rational — hemisphere, and greater activity in the right — the more emotional — hemisphere.

It is unlikely that all of the six brain areas that showed reduced metabolic activity would be affected by generalized brain dysfunction.

In the second study, the researchers looked at the medical histories of 4,269 Danish males born between 1959 and 1961. The team's obstetricians assessed birth complications at the time of delivery. Interviews conducted with the infants' mothers at the end of the first year determined whether the boys had experienced maternal rejection. The researchers used the Danish National Criminal Register to determine which of the subjects had a record of violence, theft or any other criminal behavior by the ages of 18 or 34.

By age 18, boys whose mothers had experienced obstetrical complications were no more likely to have committed a violent crime than were boys whose mothers had not. But when these boys also experienced maternal rejection, their chances of committing a violent crime more than doubled (9 percent vs. 4 percent). Rejection and complications did not, however, seem to have the same effect on offenders who committed their first violent crime between the ages of 19 and 34.

Birth complications and maternal rejection seemed to predispose offenders to some kinds of criminal offenses but not to others, such as threats of violence and weapons violations. Institutionalizing a child for four months or more during the first year of life proved to be the most detrimental form of maternal rejection in the long-run.

"Brain abnormalities in murderers indicated by positron emissions tomography." Adrian Raine, Ph.D., et al., *Journal of Biological Psychiatry*, September 1997.

"The interaction between birth complications and early maternal rejection in predisposing to adult violence: Specificity to serious, early onset violence." Adrian Raine, Ph.D., et al., *American Journal of Psychiatry* 154(9):1265-1271, 1997.

For reprints, contact Dr. Raine, Department of Psychology, S.G.M. Building, USC, Los Angeles, CA 90089-1061.

Recommended Reading

SEXUAL, PHYSICAL, AND EMOTIONAL ABUSE IN OUT-OF-HOME CARE — *Toni Cavanagh Johnson, Ph.D., and associates. The Haworth Maltreatment Press, New York, 118 pages, $14.36 (paperback), 1997, (800) 429-6784.*

Toni Cavanagh is a clinical psychologist in California, working in the field of child abuse for almost 20 years. She is as concerned with child-to-child sexual abuse as with abuse between caregivers and children. The book presents a curriculum of 20 exercises that promote nurturing behavior by offering healthy forms of touching, communication and boundaries. Attention is given to what a sex offender does to trick children into situations that lead to sexual abuse.

PREVENTIVE PARENTING WITH LOVE, ENCOURAGEMENT, AND LIMITS: THE PRE-SCHOOL YEARS — *Thomas J. Dishion, Ph.D., and Scot G. Patterson, Castalia Publishing Co., Eugene, OR, 144 pages, $10.95 (paperback), 1996, (541) 343-4433.*

This is a very practical, easy-to-read and inexpensive book purporting to "describe how to raise happy, self-confident, well-behaved children." A step-by-step approach offers solutions to everyday problems such as not minding, whining and temper tantrums. Attention is given to how parents can prevent misbehavior by supporting children's positive efforts and good behavior.

Dishion is a child psychologist, family therapist and researcher at the Oregon Social Learning Center, and is known for his extensive research on children's antisocial behavior and teenage drug abuse. Scot Patterson is the founder of Castalia Publishing, where much of Dr. Gerald Patterson's and his colleagues' pioneering work with disturbed and wayward children and adolescents is published.

EMOTIONAL DEVELOPMENT: THE ORGANIZATION OF EMOTIONAL LIFE IN THE EARLY YEARS — *L. Alan Sroufe, Cambridge University Press, New York, 263 pages, $19.95 (paperback), 1997, (800) 872-7423.*

A scholarly work, this volume is directed to teachers, students and clinicians interested in developmental, cognitive and social psychology. Researchers usually have treated the development of emotions and the task of emotional regulation as separate topics, the former emphasizing normative questions and the latter individual differences. This volume brings them both under the perspective of development and emphasizes common core processes.

Research
from page 1

Newsweek and Time have all promoted the idea that early experiences mold infants' brains, and that this determines future brain power. Parents' reading, talking and providing visual stimulation to babies are said to be critical to their later cognitive and language development.

Can it be true that specific early experiences must be programmed to ensure that babies will become normal adults? Hardly. If our species had evolved to require scarce or unusual experiences for normal development to occur, humans would be extinct. Cultural variations in child-rearing practices around the world demonstrate that normal human development occurs in many different environments. Reading is one way to interact with babies, but it's not the only right way.

Caring parents are effective parents

Language acquisition depends on hearing adult speech, but what infant is not exposed to any human speech? Even the hearing children of deaf parents develop into normal speakers of their native languages, if they hear other people speak for only a few hours each week. This is not to say that we shouldn't talk and read to babies; I did, and so do many other parents. But it is wrong to say that this is the only way to produce cognitively and linguistically normal human beings.

Critics are quick to point out that getting parents to focus positive attention on their babies for any reason can't hurt. But why evoke worry and guilt in working parents about their children's development, when we know that caring parents who engage in culturally ordinary interactions with their children will do just fine?

Another symptom of experts' misplaced concern about recent child-rearing practices is the repetition of studies about the potentially harmful effects of low-quality child care.

In April, the National Institute of Child Health and Human Development released a report saying that young children who are cared for by adults other than their parents have normal cognitive, linguistic, social and emotional development. The report, based on an $88 million longitudinal study, is hardly the first to reach this conclusion. And the researchers reported another reassuring, but not novel, finding: The quality of infant care, which ranged from poor to excellent for the 1,200 children in this study, had no impact on young children's development, and only small effects on their preschool cognitive, social and emotional development, although good-quality day care can to some extent make up for poor parenting.

Caring parents who engage in culturally ordinary interactions with their children will do just fine.

Further, by the time the children reached school age, the studies found that the small early differences had vanished.

These results, which could be so reassuring to hard-pressed working parents, have not stopped the fretting by some experts, however. Quality of care must matter, they argue, or most developmental theories, which stress the lasting importance of children's early environments, must be wrong.

The fact that child care deemed by childhood researchers to be of poor to medium quality could have little negative effect on children is unpredicted and disturbing. That day care is just as beneficial to children as full-time parental care is a theoretical and emotional blow to some experts.

Unfortunately, some environments *are* so poor that they endanger children's lives and development, and those should not be tolerated. But the need to improve some very poor care does not justifying frightening American parents in general, when the results of several major studies could be used to calm their worst fears about their children's development.

Scholars need to take a good look at their old theories and assumptions in light of this research. We can no longer say that children need full-time maternal care when studies show that other arrangements work just as well to promote healthy development. We should not claim that children need a carefully tailored environment of sensory and intellectual stimulation and emotional support from two parents (preferably one male and one female).

Children for the 21st century

We need to re-examine the ideal that children should be so exclusively attached to their mothers that they suffer when their mothers are absent. And we need to look beyond the quality of day care and its costs and benefits for working parents now that a good deal of competent research has shown how little impact variations in quality have on children's development.

The new century's ideal children will need shared care to develop essential social and emotional skills to deal with frequent job changes and relocations. They will need to be more sociable and secure with large numbers of new people than were children of the past. Teamwork will be stressed from an early age. Multiple attachments to others will become the ideal. Shyness and exclusive maternal attachment will be seen as dysfunctional. New treatments will be developed for children with exclusive maternal attachments (EMA Syndrome) and those with low sociability scores. Being isolated at home with one adult and no peers, experts will claim, retards toddlers' social and emotional development and should not be permitted.

Every culture gets the children it deserves, said a noted anthropologist. Experts' worries largely reflect their discomfort with cultural shifts in ideals for children and child rearing. Fortunately, the human species will endure, because children can thrive under many different kinds of rearing regimes. ■

Sandra Scarr is a professor emerita of psychology at the University of Virginia and former chairman and chief executive officer of Kindercare, a national chain of day care centers. She was president of the American Psychological Society in 1996-97.

Child care

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day necessity.

In places where day care is regarded as a requisite for parenthood, communities have tackled the economic and the personal/familial issues with great energy, intelligence, planfulness and regard for the variety of care situations that can work and are acceptable to the parents. Some parents prefer in-own-home care, some prefer center-care, and some like small groups of three or four youngsters taken care of by a neighbor whose work this is.

In the United States, widespread use of day care opportunities and facilities has risen at such a fast rate that our parents were not prepared. Often they do not understand the alternatives available, or the high standards of care that ought to be met before a child is entrusted to one or another type of care situation.

One consequence of the rapid entry of so many individuals into the "cottage industry" of child care has been that some centers and some homes with very poor, and in some cases, even dangerous, conditions came into existence. These unhappy instances, well-noted in the media, will not be rehashed here, but it is fair to note that even in-home care by, for example, an *au pair* girl, experienced in caring for children, does not guarantee complete safety. Nor, for that matter, does care by another member of the family — or even mother — mean that the child is always (alas) in good hands.

This issue of *The Brown University Child and Adolescent Behavior Letter* is concerned, in part, with day care and its surrounding issues — of quality, safety and our knowledge about potentially hazardous aspects of child care. There are some individuals who are dead-set against out-of-home care for children, especially for infants. But day care is now an American reality, with about 60 percent of mothers returning to work at least within several months of the birth of their children. Even if day care is only second best for some babies, as possibly it is, it is here to stay. It is therefore of the utmost importance that it be monitored by parents and by responsible community agencies.

It is of further urgency that research be promoted, financed and carried out to inform American families of (a) the variety of care opportunities available to parents, (b) the character and quality of those care situations and (c) the typical effects of different kinds of care on the developmental outcomes of children participating in those situations.

An excellent source of information, which is constantly becoming richer as more and more data are gathered, is the National Institute of Child Health and Human Development (NICHD). The NICHD is currently gathering extensive data on numerous aspects of children's development in a study of hundreds of American youngsters in different types of child care. The study is ongoing, but already has a great deal of information which has been published or is in press. Deborah Vandell, Ph.D., interviewed for the insert that accompanies this issue, is one of the major researchers in the NICHD project, along with others who are among the most prominent child care researchers in the country. As a member of the steering committee of that project (not one of the researchers), I and others associated with the study participated in the recent White House Conference on Child Care, a gathering that had the active participation of President Clinton and Hillary Clinton. This conference clearly affirmed our government's research initiative into American child care practices. From this effort, one hopes, there will emerge clear guidelines for increasing the availability of high-quality, economically feasible child care for all parents who desire it in this country. ■

For more information, contact the National Institute of Child Health and Human Development at NICHD, CRMC, LDCSD, Executive Building, Room 4B05G, 6100 Executive Blvd., MSC 7510, Bethesda, MD 20892-7510.

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Guest Commentary

Skeptics refuse to accept child care research

By Craig Hayward

America has an uneasy relationship with intellectuals. On the one hand they are venerated as champions of progress. But on a more concrete level, science is often seen as the playground of nerds and geeks. This current of anti-intellectualism runs deep and sometimes surfaces in strange places.

For example, an ongoing study by the National Institute of Child Health and Human Development (NICHD) suggests that having children in high-quality day care has no harmful effects. Some naysayers, however, including a few child development experts, in their response to this have slipped into the worst sort of "anti-science." Because there are conflicting views among researchers, they reason, chuck all the diligently gathered evidence out the window (the baby with the day care, as it were). Disagreement among experts is seen as cause for disregarding *all* expert opinion.

No matter how attractive the idea, people of recent decades past did not live in some sort of Norman Rockwell town where everyone really cared and life was uniformly good.

I wince when I see otherwise intelligent, well-meaning people fall to these types of conclusions. The results of scientific studies that have taken thousands of skilled people-hours to compile deserve more consideration. Is there any evidence that the current ills of society have been caused by day care, or that, until day care in the industrial age, people were happier and more fulfilled in their roles as sole breadwinner or as housewife in perpetuity?

I would call such ideas misguided nostalgia for a time that never really existed. Surely we can all cite examples of families from decades past that were far from ideal. But without any reference to hard numbers, it is a bootless discussion.

No matter how attractive the idea, people of recent decades past did not live in some sort of Norman Rockwell town where everyone really cared and life was uniformly good. The seeds of today's precarious social world were contained in that mythical time. Those Norman Rockwell kids grew up to be the parents who divorce and who obsess about their material status.

Another myth that is perpetuated in this kind of faulty vision is that children of divorce are necessarily screwed up. The fact is that parents who divorce today might have stayed in an unhappy marriage years ago before norms had changed. And there is no evidence that parents who stay in an unhappy marriage provide a better environment for growing children than do parents who divorce and move on. The "anti-science" perspective also ignores all the children who have grown up in single-parent or remarried homes who are getting a college education and are raising a happy family of their own.

This doesn't mean I'm pro-divorce. I'm just in favor of a scientific consideration of all the available evidence before jumping to conclusions.

As for the value of the NICHD study of early child care, measuring human behavior is a difficult proposition. So many things influence us that it is a wonder that scientists have been able to glean any reliable information at all. But they have.

Numerous studies on day care are ongoing. Each year the scientists release more new information, as children develop and their behavior becomes more complex. It is not a case of old wine in new bottles, and not all the proverbial and omniscient grandmothers are going to turn out to be right — we have to see what the data will teach us.

Consider the possible effects of day care on a two-year-old. Whatever they might be they are limited by the capabilities of a two-year-old. As the child develops, scientists can see more and more behaviors, and the effects of different early child care arrangements will become clearer.

It is important, of course, for social scientists, whether studying the effects of child care, divorce or any other important aspect of childhood experience, to be clear about their findings lest the public hear the skeptical voices and assume that all social science research is smoke and mirrors. ■

Craig Hayward is a research assistant in the Study of Early Child Care at the University of California at Irvine, where he is in the doctoral training program. He has a bachelor's degree in journalism.

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

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